

**A 21ST CENTURY MEDICARE: BIPARTISAN
PROPOSALS TO REDESIGN THE PROGRAM'S
OUTDATED BENEFIT STRUCTURE**

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A 21ST CENTURY MEDICARE: BIPARTISAN PROPOSALS TO REDESIGN THE PROGRAM'S OUTDATED BENEFIT STRUCTURE

WEDNESDAY, JUNE 26, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:59 a.m., in room 2322 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Burgess, Shimkus, Blackburn, Lance, Cassidy, Guthrie, Bilirakis, Barton, Pallone, Dingell, Engel, Green, Barrow, Christensen, Castor, and Waxman (ex officio).

Staff present: Clay Alspach, Chief Counsel, Health; Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Sydne Harwick, Legislative Clerk; Katie Novaria, Professional Staff Member, Health; Monica Popp, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; Chris Sarley, Policy Coordinator, Environment and Economy; Heidi Stirrup, Health Policy Coordinator; Alli Corr, Democratic Policy Analyst; Amy Hall, Democratic Senior Professional Staff Member; and Karen Nelson, Democratic Deputy Committee Staff Director for Health.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. This subcommittee will come to order. The chair recognizes himself for 5 minutes for an opening statement.

Nearly 50 million seniors rely on the Medicare program for their health care, and that number may grow to 63 million Americans by 2020 and 81 million by 2030. Medicare's traditional benefit design mirrored the private insurance products, namely Blue Cross Blue Shield plans, available in the mid-1960s. While the private insurance market has undergone significant changes in the last 50 years, Medicare's traditional benefit structure has remained fundamentally the same.

Unlike most private insurance today, which has a single deductible for all medical services, traditional Medicare has separate deductibles and copayments for Part A, hospital services, and Part

B, physician and outpatient services. The program also charges separate copayments for Part A and Part B services.

Today, seniors face great uncertainty about what their out-of-pocket costs will be. Generally, Medicare requires a 20 percent copayment, but without knowing the total cost of a doctor's visit, a hospitalization, or a procedure or test, seniors don't know what that 20 percent means in dollars until after a service is delivered. With no cap on out-of-pocket spending a beneficiary can incur, and confusion about the lack of coordination between Parts A and B, nine out of ten Medicare beneficiaries purchase supplemental insurance.

On April 11, 2013, the subcommittee held a hearing titled "Strengthening Medicare for Seniors: Understanding the Challenges of Traditional Medicare's Benefit Design," at which MedPAC Chairman Glenn Hackbarth discussed ways to modernize and improve Medicare's traditional benefit design. As I said at that hearing, everything about our health care system has changed dramatically since 1965. Today's standards of care, and the tests, treatments, and drugs we have access to were not even dreamed of when the program was created.

Our expectations have changed as well. Fifty years ago, insurance protected us from catastrophic hospital costs incurred as a result of diseases, which were most likely fatal. With the medical breakthroughs we have experienced in the ensuing decades, many of those diseases have become chronic conditions and we expect our insurance to help us manage them accordingly. Seniors deserve an insurance product that reflects the current health care system, not that of the last century.

Today's hearing builds on MedPAC's recommendations, by bringing in policy experts to further explore how we can make the program work better for our seniors.

I would like to thank our witnesses for being here today. I look forward to their comments on some of the reforms we discussed at the previous hearing, such as combining Parts A and B under a unified cost-sharing structure, instituting a cap on out-of-pocket spending to protect beneficiaries from the threat of medical bankruptcy, incentivizing high-value care, and others.

Thank you, and I yield the remainder of my time to Representative Burgess.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The Subcommittee will come to order.

The Chair will recognize himself for an opening statement.

Nearly 50 million seniors rely on the Medicare program for their health care, and that number may grow to 63 million Americans by 2020 and 81 million by 2030.

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Thank you, and I yield the remainder of my time to Rep.

Mr. BURGESS. I thank the chairman for yielding. I thank you for having the hearing, and I thank our witnesses for being here today.

In its current form, Medicare has made some promises that may be very difficult to keep in just a few short years. It shouldn't be a surprise, since we expect the program designed in 1965 to adapt to the needs and usage patterns of beneficiaries in the 21st century.

Enrollment in Medicare could reach well over 60 million people by 2020. In 2013, Medicare costs are estimated to be a little over 3½ percent of GDP. That will be almost 6 percent in 2035, so certainly a substantial increase. The primary reason for the increase is the demographic shift—there are more people in the program, baby boomers leave the workforce and join the rolls of retirees. We should undertake an open-minded review of the current benefit design in Medicare and ways to reform it in a way that reflects the needs and expectations of today's seniors. We also must adapt to the needs of future beneficiaries. So let us have that conversation about innovative payment and care programs. Let us empower patients and providers by promoting quality measures that are meaningful to consumers that they can understand. Let us offer incentives in the program to promote better organized, coordinated health care delivery and payment systems.

Many of these are tenets guiding our discussions around replacing the Sustainable Growth Rate formula, and that is a good thing, but we must move toward a system that allows all beneficiaries a choice between improved fee-for-service, Medicare Advantage, alternative payment models such as ACOs bundling. Just as each provider should be able to flourish, we must allow patients a choice, a meaningful choice, in how they receive their care.

I thank the chairman for the recognition and I will yield back the time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member of the subcommittee, Mr. Pallone, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE JR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairman Pitts, and thank you for holding this hearing today.

Improving and strengthening Medicare so that the program can serve as a reliable resource for seniors and the disabled for years to come is critically important. We must continue to examine ways to keep the program solvent as the number of beneficiaries grows from an aging baby boomer population, and we have already made important progress in this area with the delivery-system reforms in the Affordable Care Act.

According to the annual Medicare's trustee's report, Medicare spending growth is down and is projected to continue to have slower growth than the overall economy for the next several years, and I am committed to exploring ways to continue moving in this direction and modernizing Medicare so that beneficiaries today and in the future receive the care they need in an efficient and affordable manner.

Seniors and individuals with disabilities rely on Medicare to access needed health services. These individuals are some of the country's poorest and sickest. Medicare beneficiaries, half of whom have an annual income under \$22,500, spend disproportionately more on health care than the general population. As we consider Medicare benefit redesign, we must protect and improve this population's access to quality, affordable health care.

Now, reform should provide greater predictability and security for beneficiaries. For years, my colleagues and I have explored the idea of establishing out-of-pocket limits to protect seniors and individuals with disabilities from catastrophic medical expenses. This is also an opportunity to improve the Medicare benefit design, making it less complicated. The fact that Part A and Part B have such divergent cost sharing and deductibles can seem arbitrary and confusing to beneficiaries. We should examine ways to move away from this model towards one that is more streamlined. Yet we must ensure that any changes that we make to restructure Medicare do not come at the expense of beneficiaries' health or financial security. Any reform, particularly proposals that include changes in beneficiary cost sharing, must take into consideration how the changes will impact a vulnerable beneficiary population. For example, while reducing utilization of unnecessary health services that welcome change, Medicare beneficiaries are not always able to distinguish between unnecessary and necessary care. When faced with higher costs, some beneficiaries will simply reduce their use of services across the board. Older, sicker seniors in particular are more likely to be passive in their care decision-making than the general population and rely on their providers to steer them toward recommended use. That is why we must continue to support comprehensive approaches that help move our health care system to a more value-based system including provider payment models that

support value over volume, and the Affordable Care Act laid the groundwork for this, and we must continue down that path.

So I look forward to hearing from our witnesses today about their ideas to improve Medicare's benefit structure and look forward to working with my colleagues towards a system that incentivizes high-quality and high-value care while building in protections for low-income and vulnerable populations. Thank you, Mr. Chairman.

Mr. PITTS. The chair—

Mr. PALLONE. Mr. Chairman, I have three statements for the record that if I could submit—I ask unanimous consent to enter into the record a statement from the American Federation of State, County and Municipal Employees, AFSCME, second, a joint statement from the California Health Advocate Center for Medicare Advocacy and Medicare Rights Center, and lastly, the National Association for Home Care and Hospice.

Mr. PITTS. Without objection, so ordered.

Mr. PALLONE. Thank you.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. We have more than one subcommittee going at the same time, so members will be in and out today. I apologize for that.

At this time the chair recognizes the ranking member of the ranking member of the full committee, Mr. Waxman, 5 minutes for opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman. I appreciate your holding this hearing.

The Medicare program been critical to ensuring the health and financial security of seniors and disabled Americans since its inception, and while I know we agree that there are a number of ways we can improve quality and efficiency in Medicare, we should also work on broader health care delivery system reform. I hope we also agree that we must preserve the strengths of the program and its protections for the vulnerable populations that depend on it.

It is critical, as we explore this topic, that we are mindful of who the Medicare beneficiaries are. Two recent reports looking at the supplemental poverty measure—one by Kaiser Family Foundation and the other by the Economic Policy Institute—remind us of the financial vulnerability of seniors across the country. Nationally, nearly half of all seniors live with incomes below twice the poverty threshold. In my home State of California, the number is 56 percent, with 20 percent, or one in five seniors, living in poverty. Any proposal to redesign Medicare that doesn't protect these vulnerable seniors or looks to achieve program savings by shifting costs to beneficiaries is not one that I can endorse.

I am glad to see that a key element of the models proposed by both Kaiser and MedPAC is that they are cost-neutral to beneficiaries overall. At the same time, I understand that there will inevitably be winners and losers within the Medicare population.

I can't emphasize enough the critical importance of ensuring that the full impact, both economically and in health term, is considered

across the population of beneficiaries. In our health care system today, among both private and public payers, there is a lack of alignment between cost sharing and value. As Dr. Baicker has indicated in some of her work, cost sharing is a blunt tool that doesn't help beneficiaries distinguish between high-value and low-value services. In the same way that the Affordable Care Act removed cost sharing for age-appropriate preventive services, we know from the private market that reducing cost sharing for prescriptions and follow-up care for people with chronic medical problems improves adherence and health outcomes.

There is a lot of interest in eliminating first-dollar coverage as a strategy to reduce unnecessary utilization. Yet we know that in poorer, sicker populations, like those in Medicare, this kind of cost sharing reduces both necessary and unnecessary care. Reducing necessary care and having patients defer appropriate outpatient care and end up in emergency departments or admitted to the hospital is not the outcome we are looking to achieve. More value-based benefit design must be tailored to the beneficiaries. For Medicare, that means building in incentives for high-value care and ensuring protections for low-income and other vulnerable members.

In closing, I believe there are a number of ways to improve the benefit design in Medicare that are accountable to both beneficiaries and taxpayers. In the process, we must continue to protect our most vulnerable seniors, and we must make sure that we are not using program redesign as a pretext for achieving program savings by shifting costs onto the beneficiaries. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. That concludes our opening statements.

We have one panel today. On our panel we have today Dr. Katherine Baicker, Professor of Health Economics, Department of Health Policy and Management, Harvard School of Public Health; Dr. Patricia Neuman, Senior Vice President of the Henry J. Kaiser Family Foundation; and Mr. Thomas Miller, Resident Fellow, American Enterprise Institute.

Thank you all for coming today. Your written testimony will be entered into the record. You will be given 5 minutes each to summarize your testimony, and at this point we will recognize Dr. Baicker for her opening statement.

STATEMENTS OF DR. KATHERINE BAICKER, PROFESSOR, HEALTH ECONOMICS, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD SCHOOL OF PUBLIC HEALTH; DR. PATRICIA NEUMAN, SENIOR VICE PRESIDENT, THE HENRY J. KAISER FAMILY FOUNDATION; AND THOMAS MILLER, J.D., RESIDENT FELLOW, THE AMERICAN ENTERPRISE INSTITUTE

STATEMENT OF KATHERINE BAICKER

Ms. BAICKER. Chairman Pitts, Ranking Member Pallone, members of the committee, I am really honored to have the opportunity to talk with you today about this crucial topic of improving Medicare's benefit design, and this offers the opportunity to not only im-

prove the benefit that current enrollees receive but ensures fiscal stability for generations to come.

So I wanted to spend a minute talking about balancing two competing factors. I am an economist. I have two hands. I always use that. That is insurance and incentives. The fundamental goal of an insurance product is not only to get people access to needed care but to protect them from financial ruin. Seniors shouldn't have to spend their life savings if they fall ill and their children shouldn't fall into financial ruin to care for an elderly, ailing parent. So it is vital that Medicare offer that kind of financial protection that any good insurance product should.

But balanced against that are the incentives that any insurance product creates. When you subsidize care, people consume more of it. We have decades of research that shows that even though it is not intuitive that people consume health care that way, when the price of health care goes down, people consume more and some of that is really valuable care but incrementally it gets less and less valuable to the point that it might even have negative value. So we need to balance those two competing interests in designing a smart insurance product.

The question is, how does Medicare do on that balance, and I fear that the answer is right now, not so well. It does not offer vital financial protections. Seniors without supplemental plans face potentially unlimited out-of-pocket costs, as you mentioned, that is not a good insurance product for them. On the other hand, if seniors get supplemental insurance coverage, they then go from having too little insurance to potentially too much where their care is subsidized on a first-dollar way that encourages care of potentially questionable value. We know that in any given year, about 15 percent of seniors if they don't have supplemental coverage face out-of-pocket expenses of more than \$2,500 but over 10 years more than half of enrollees in Medicare without supplemental coverage would face more than \$2,500 in expenses. The typical Social Security retiree's income is less than \$20,000, so that is a huge amount of money for someone with Medicare. That is why 90 percent of them, as you noted, are likely to purchase that supplemental coverage.

The challenge is that the extra care that the supplemental coverage creates really falls on the shoulders of the Medicare program. The supplemental coverage only pays for part of it. If an enrollee goes to the hospital one more time than is necessary for good care, that is not good for the enrollee who does not want to be in the hospital but it is also bad for the Medicare program because the program is shouldering most of those costs. So an ideal system would provide beneficiaries with the kind of protection they needed through the Medicare program and then they wouldn't need to purchase the supplemental coverage that raises the cost of the Medicare program and threatens its financial viability for future generations.

So how do we improve the benefit design? As Representative Waxman noted, crude cost sharing can do as much harm as good. Nuanced cost sharing, I think, has the potential to improve the quality and value of care that seniors get while reducing unnecessary or low-value care that burdens the current system, and that

means that cost sharing for different services should be different. It should be value-based cost sharing where care that is of high value should come with little or no cost sharing at all, and cost sharing should be ratcheted up depending on how the value of care diminishes. Care that has very little health benefit for seniors should come with a substantial copayment. It is important to protect low-income seniors from financial risk exposure. Again, it is an insurance product. You can't expose people to financial ruin, but that cost sharing could be based on income as well.

The last point I would like to leave you with is that looking across silos would very much improve the balance between insurance and affordability for the Medicare program, and by that I mean, care consumed in one setting—pharmaceuticals, doctor's office visits—has implications for care consumed in other settings—hospitalizations, emergency department visits. Patients need to have the right incentives to consume care in the setting that produces the best health value for them. Providers need to think across silos. Physicians should be thinking what are the downstream consequences for emergency department visits, and insurance products need to look across silos. If subsidizing a physician's office visit keeps a patient out of the emergency room, the insurer should be working in a system that encourages that because that is good for the patient and it is good for costs. So improving the program in this way would have far-ranging implications. It would improve the value for beneficiaries, it would improve the fiscal stability of the system. It also has the potential to improve the care consumed by all patients in the Medicare system and privately insured patients. There are spillover effects. If physicians and hospitals do a better job for our Medicare beneficiaries, all patients will benefit from that higher standard of care.

Thank you for this opportunity, and I look forward to answering your questions.

[The prepared statement of Ms. Baicker follows:]



HARVARD SCHOOL OF PUBLIC HEALTH
DEPARTMENT OF HEALTH POLICY AND MANAGEMENT

KATHERINE BAICKER
PROFESSOR OF HEALTH ECONOMICS

June 26, 2013

My name is Katherine Baicker, and I am a Professor of Health Economics in the Department of Health Policy and Management at the Harvard School of Public Health. I would like to thank Chairman Pitts, Ranking Member Pallone, and the Distinguished Members of the Committee for giving me the opportunity to speak today about how we can address the crucial policy challenge of making Medicare work better for beneficiaries and ensuring that it provides the vital protections they need for generations to come. This testimony is derived in large part from recent academic work with my colleague Helen Levy that appeared in the *New England Journal of Medicine*. I summarize that work here.

Medicare is an insurance program. The reason we have health insurance at all is not because health care is expensive, but rather because there is great uncertainty about who will need very expensive and potentially life-saving care and when they will need it. Medicare should give beneficiaries not just access to medical care, but also protection from the risk of catastrophic spending. At the same time, Medicare – like any good insurance – should not cover so much care so generously that beneficiaries end up consuming too much care of questionable value and driving up costs for everyone. This means that beneficiary cost-sharing in Medicare is a balancing act: too little cost-sharing means patients have no incentive to spend Medicare dollars wisely; too much cost-sharing means Medicare fails to perform its insurance function.

How well does Medicare do at this balancing act? Not very. Medicare by itself offers only limited protection against economic ruin. The basic benefit lacks a cap on out-of-pocket spending, so that beneficiaries are exposed to the risk of open-ended cost-sharing. Moreover, the odds of facing a catastrophic expense mount over time. Almost half of beneficiaries are hospitalized at least once in a four year window.¹ Without supplemental insurance, 14.5% of beneficiaries would have faced out-of-pocket expenses of more than \$2,500 in 2009, and more than half of beneficiaries would have had at least one year between 2000-2009 where they faced \$2,500 or more in out-of-pocket expenses (see Exhibit). 15% would have had at least one year between 2000-2009 where they faced more than \$5,000 in out-of-pocket expenses – or more than a third of the average annual Social Security income for a retired worker. And these figures are for hospital, outpatient facility, and physician care only – beneficiaries face additional cost-sharing liability for other categories of care such as prescription drugs, medical equipment, and skilled nursing facilities.

Beneficiaries without any supplemental coverage thus do not have enough insurance and face too much risk. This risk is one reason that 90 percent of beneficiaries obtain some other insurance (retiree health benefits, MediGap, Medicare Advantage, or Medicaid).¹ But beneficiaries with generous supplemental coverage probably have too much insurance. “Too much insurance” may seem like a nonsensical concept, but there is ample evidence that lower copays result in more care, much of it of questionable benefit to health.² Beyond the fact that many supplemental plans

are quite expensive for beneficiaries, they substantially raise Medicare program spending.¹⁻⁵ The system-wide effects are large, including changes in practice patterns and investment in infrastructure; the spread of insurance is estimated to be responsible for about half of the rise in per capita health spending between 1950 and 1990.⁶ Having little or no cost-sharing leads enrollees to consume low-value care and drives up the cost of Medicare for everyone.

As a Medicare solvency crisis approaches slowly but inexorably, pressure to restructure the program in order to reduce spending will only increase. Proposed reforms are typically evaluated on how they impact the bottom line: the HI Trust Fund exhaustion date or the share of GDP devoted to Medicare. They are also evaluated on whether their burden is borne, on average, by providers or by beneficiaries. These metrics are not enough. Reforms must also be evaluated on how they affect the risk of potentially high expenditures to which beneficiaries are exposed – striking a better balance between financial protection on the one hand and preserving incentives to consume care wisely on the other.

Technological innovation raises the stakes. Many new technologies are crucial for extending life and improving well-being, but also add even greater uncertainty about health spending both for individuals and for the health care system overall. Mounting budgetary pressures highlight the fiscal unsustainability and economic costs of the current financing and benefit structure.⁷⁻¹⁰ These costs rise as Medicare covers an increasing array of treatments that may not be what most enrollees would choose if they were spending their own money.

Nonpartisan and bipartisan groups have advanced proposals that would address the imbalance in risk facing beneficiaries in the current Medicare program. Although these groups do not propose exactly the same fixes, some of the basic ideas are the same: first, put a cap on the out-of-pocket spending beneficiaries are responsible for – just like most private plans already do – so that beneficiaries without any other coverage are protected from catastrophic costs. Second, restrict “first-dollar coverage” (coverage with no beneficiary cost-sharing) in Medicare supplemental insurance, either by banning it or by imposing a surcharge on plans that provide it. This surcharge would reflect the additional cost to the Medicare program imposed by the extra use of (low-value) care by beneficiaries who face no cost-sharing because of the supplemental plan – since the private premiums charged for those plans do not reflect that additional public cost.

There are of course many challenges in implementing such proposals. Crude cost-sharing that ignores the differences in health benefits produced by different types of care could reduce use of highly effective care as much as it reduces use of low-value care, especially for low-income populations.¹¹ A more sophisticated value-based approach would be to keep cost sharing lowest for services that are most effective at improving health.^{12,13} The value of care delivered would also be improved by promoting coordination across silos – both in insurance and in care delivery. Evidence suggests that insurance features that drive use of one type of care (such as physician visits or medications) may have spillover effects on other kinds of care (such as hospitalizations or emergency department visits) that insurers as well as providers should have incentives to take into account.¹⁴⁻¹⁶

Striking a better balance between spreading risk and promoting efficiency would make Medicare a better insurance program. Improving the efficiency with which care is delivered to Medicare

beneficiaries also has the potential to improve system-level delivery. The Medicare Advantage program was introduced in that hope that private competition and managed care would result in more efficient care at a lower cost than conventional fee-for-service health insurance.¹⁷ Accountable Care Organizations also aim to improve the value of care delivered through improved coordination. Because the same health care providers generally serve patients with different insurance coverage, changes in care induced by these programs may “spill over” to care delivered to other Medicare enrollees and, indeed, to all patients. Research suggests that these spillovers may be substantial.¹⁸⁻²²

Medicare was always intended not just to increase access to care but to protect the elderly from financial ruin. As President Johnson said when signing Medicare into law in 1965, “No longer will illness crush and destroy the savings that [older Americans] have so carefully put away over a lifetime so that they might enjoy dignity in their later years.”²³ Indeed, the introduction of Medicare reduced out-of-pocket spending among the top quartile of spenders by 40%.²⁴ Will Medicare continue to fulfill this promise in decades to come? President Reagan highlighted the need for the reform of Medicare’s benefit: “All of us have family, friends, or neighbors who have suffered devastating illnesses that threatened their financial security. For too long older Americans, in particular, have faced the possibility of sicknesses that might not only wipe out their own savings but those of their families.”²⁵ Medicare reforms that strike a balance between financial protection and financial incentives will help ensure that the program will be solvent for future generations without undermining the fundamental insurance value of this public insurance program.

EXHIBIT

Medicare Beneficiaries' Annual Cost-Sharing Liability for Hospital, Outpatient, and Physician Use				
	Year 2009	Any Year in 2007-9	Any Year in 2005-9	Any Year in 2000-9
Share with Cost-Sharing Liability (Percent):				
Over \$1,000	35.6	60.0	72.6	87.2
Over \$2,500	14.5	27.9	37.4	53.2
Over \$5,000	4.0	7.5	10.1	15.1
Over \$10,000	0.9	1.6	2.0	2.4
Average Expenditures (\$)				
Medicare	8587	8288	8226	7857
Beneficiary Cost-Sharing	1279	1254	1252	1232

Source: Baicker and Levy, *New England Journal of Medicine*.²⁶

Notes: Data from Medicare Claims files for inpatient, outpatient, and carrier (physician) use, expressed in 2009 dollars. The entries show the share of beneficiaries facing cost-sharing liability above the threshold for each row in any single year within the window for each column. For example, while 4.0% of beneficiaries had cost-sharing liability above \$5,000 in 2009, 10.1% had annual cost sharing liability above \$5,000 in at least one year between 2005 and 2009. These figures exclude other categories of care (such as durable medical equipment) covered by Medicare for which beneficiaries may also incur cost-sharing liability. MedPAC estimates for 2009 that include the cost-sharing liability from all categories covered by Parts A and B (but not prescription drugs) suggest that 6.0% of beneficiaries would face cost-sharing liability of above \$5,000, for example.¹ This cost-sharing liability may be paid out-of-pocket or by a third party (such as a Medigap plan).

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Mr. PITTS. The chair thanks the gentlelady.

Dr. Neuman, you are recognized for 5 minutes for an opening statement.

STATEMENT OF PATRICIA NEUMAN

Ms. NEUMAN. Thank you, Chairman Pitts and Ranking Member Pallone and distinguished subcommittee members. I appreciate the opportunity to be here with you this morning to talk about restructuring the Medicare benefit design.

Medicare provides highly valued health insurance for more than 50 million elderly and disabled Americans, many of whom have significant medical needs and modest incomes. Four in 10 have three chronic conditions, one in four has a mental or cognitive impairment such as Alzheimer's disease, and half live on an income of less than \$23,000. Medicare, as we have heard, has a very complex benefit design with multiple deductibles, variable coinsurance per service, and no limit on out-of-pocket spending.

To ease concerns about unpredictable and unaffordable medical bills, most have some form of supplemental insurance. Nonetheless, elderly and disabled people in Medicare tend to have relatively high out-of-pocket health care expenses. Health expenses including premiums consume three times the share of Medicare household budgets as it does for non-Medicare household budgets, 15 percent versus 5 percent. Half of all Medicare beneficiaries with incomes below \$20,000 spend at least 20 percent of their income on health-related expenses.

The idea of simplifying Medicare benefits and strengthening protections for seniors with catastrophic expenses has been one that has been under discussion for years, for decades, and has emerged more recently in the context of deficit reduction discussions. Modifications to the Medicare benefit structure could be designed to achieve any number of goals. Reforms could be designed to generate Medicare savings, to streamline benefits, to add catastrophic protections, to maintain the overall value of the Medicare benefit package while making improvements. They could also be designed to add greatly predictability for beneficiaries, to make Medicare more affordable for people with limited incomes, to reduce the need for supplemental coverage, and to nudge beneficiaries toward high-value services. But achieving all of these important goals at the same time is a very high bar.

To understand the potential implications of such proposals for beneficiaries and program spending, the Kaiser Family Foundation with Actuarial Research Corporation examined an approach specified by the Congressional Budget Office in 2011 that included a combined Part A and B deductible at \$550, uniform coinsurance at 20 percent, and a new \$5,500 cost-sharing limit. This was not a Kaiser Family Foundation proposal; it was the CBO budget option that we analyzed. This option, if fully implemented in 2013, would be expected to reduce out-of-pocket spending for a small share of the Medicare population, generally those who are quite sick, but 71 percent would be expected to face higher costs than they would under the current benefit design in this year. Seniors in relatively good health without an inpatient stay would see their deductible more than triple from \$147 under current law to \$550 if it were

the combined deductible. Yet 5 percent of beneficiaries would be expected to have lower costs than they would. Again, these are sick beneficiaries, people who have inpatient stays, post-acute care, the people who would greatly benefit from a limit on out-of-pocket spending, and over a longer term, a larger share of the Medicare population would benefit from a limit on out-of-pocket spending. MedPAC and the Kaiser Family Foundation recently released an analysis that shows 32 percent of beneficiaries in traditional Medicare would have cost-sharing liabilities that reach or exceed \$5,000 over a 10-year period.

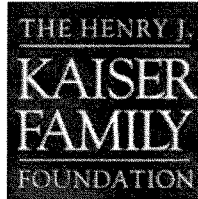
Benefit redesign proposals can be modified to achieve different objectives, resulting in tradeoffs for beneficiaries for program spending and for other payers. Lowering the cost-sharing limit, for example, from, say, \$5,500 to \$4,000 would help a larger share of the Medicare population but also reduce the Medicare savings. The reverse would also be true. Raising cost sharing for specific services such as home health care would increase Medicare savings but also shift costs onto seniors and increase the risk that at least some would go without necessary care.

Strengthening financial protections for low-income beneficiaries would make the redesign more affordable for seniors with modest incomes but could also erode the Medicare savings unless costs are offset in some fashion. An example of a benefit design that does introduce low-income protections was included in the bipartisan Policy Center initiative that was released earlier this year.

Some of the recent benefit design proposals also recommend restrictions or penalties for supplemental coverage, Medigap or employer-sponsored retiree health plans. Adding restrictions to first-dollar Medigap would greatly increase Medicare savings according to CBO, possibly because Medigap enrollees would use fewer services when confronted with higher cost sharing. A premium surcharge would increase savings by raising revenues from seniors who choose to pay the fee in their Medigap or retiree plans but also by reducing utilization among those who respond to the new fee by dropping their coverage, and presumably that would be more likely to be people with more modest incomes.

In sum, restructuring Medicare benefit design presents a really important opportunity to addressing longstanding concerns. However, simultaneously achieving the multiple goals of various benefit design proposals is a challenge. Protections for middle- and low-income seniors could be incorporated into a benefit design proposal but may come at a cost and could be compromised if savings are a high priority.

I thank you, Mr. Chairman, and I look forward to your questions.
[The prepared statement of Ms. Neuman follows:]



**RETHINKING MEDICARE'S BENEFIT DESIGN:
OPPORTUNITIES AND CHALLENGES**

**Patricia Neuman, Sc.D.
Director, Program on Medicare Policy and
Senior Vice President, The Henry J. Kaiser Family Foundation**

**Prepared for the Energy & Commerce Committee
Subcommittee on Health**

**"A 21st Century Medicare: Bipartisan Proposals to Redesign the
Program's Outdated Benefit Structure"**

June 26, 2013

Patricia Neuman, Sc.D.
Summary Statement
Energy & Commerce Subcommittee on Health
June 26, 2013

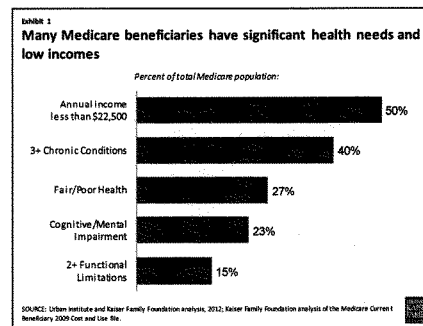
- Medicare is a popular program that serves beneficiaries with significant needs and modest incomes. Roughly one in four is in fair or poor health and about the same share has a cognitive or mental impairment, such as Alzheimer's disease. Half live on incomes below \$23,000.
- Traditional Medicare has a complex benefit design, with relatively high cost sharing, and no out-of-pocket spending limit. Most beneficiaries in traditional Medicare have supplemental insurance to ease concerns about unpredictable health expenses.
- Even with Medicare and supplemental coverage, beneficiaries have high out-of-pocket costs, spending three times as much of their household budgets on health expenses as do non-Medicare households. Among beneficiaries with incomes below \$20,000, half spend *at least* one-fifth of their income on health care and premiums.
- Proposals to restructure the benefit design have the potential to provide needed catastrophic protection, streamline benefits, coax beneficiaries toward higher-value services, strengthen financial protections for low-income beneficiaries, maintain the average value of benefits, and produce Medicare savings. But, achieving all of these goals simultaneously is a challenge.
- The CBO option analyzed by the Kaiser Family Foundation in 2011 (a unified \$550 deductible, a uniform 20% coinsurance, and a \$5,500 spending limit) would provide substantial help to a small number of traditional Medicare beneficiaries with high expenses in a given year if fully implemented in 2013. But it would increase costs for most (71%), including beneficiaries without an inpatient stay whose deductible would more than triple from \$147 to \$550.
- If measured over multiple years, a larger share of beneficiaries would reach a limit on out-of-pocket spending. One-third of traditional Medicare beneficiaries would be expected to have cost-sharing liabilities that reach \$5,000 one or more times over a 10-year period, according to recent analysis released by MedPAC and the Kaiser Family Foundation.
- In addition to benefit redesign, some proposals would restrict or impose a premium surcharge on supplemental coverage. Adding Medigap restrictions to the benefit redesign would greatly increase Medicare savings, according to CBO, perhaps because Medigap enrollees would be expected to use fewer services when confronted with higher cost-sharing. A premium surcharge would also increase savings by raising revenues from beneficiaries who choose to pay the surcharge, and by reducing utilization among those who respond to the new fee by dropping their supplemental coverage.
- Benefit redesign proposals could be – and have been – modified to achieve different outcomes. These policy decisions involve tradeoffs for beneficiaries, program spending, and other payers. For example, reducing the out-of-pocket limit would help more people, but reduce Medicare savings. Reducing lowering-sharing obligations for lower-income seniors, perhaps modeled on Part D, could help make benefit redesign more affordable for that group, but may erode savings, unless offsets are found elsewhere. Raising cost sharing for specific services could increase savings, but increase costs for beneficiaries, and risk some foregoing needed care.
- Achieving the multiple goals of benefit redesign proposals presents an opportunity to address long-standing concerns. However, protections for seniors can come with a cost and could be compromised if savings are a priority.

Chairman Pitts, Ranking Member Pallone, and distinguished members of the Subcommittee on Health, I am Tricia Neuman, a Senior Vice President at the Kaiser Family Foundation and Director of the Foundation's Program on Medicare Policy. The Kaiser Family Foundation is an independent, non-profit private operating foundation that is focused on health policy analysis, communications and journalism.

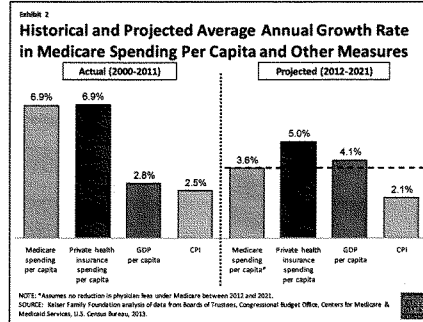
Thank you for the opportunity to testify on the topic of Medicare's benefit design, and the implications of possible changes for beneficiaries, other stakeholders, and program spending. The idea of simplifying Medicare's benefit design has been under discussion since the 1970s. A restructured benefit design could simplify and add predictability to Medicare cost sharing, protect beneficiaries against catastrophic expenses, reduce the need for supplemental insurance, encourage the use of high-value services, and strengthen financial protections for beneficiaries with low-incomes – an important feature of recent proposals given the substantial financial burden many on Medicare currently face. Achieving these multiple goals of benefit redesign proposals, without increasing the financial burden of care for seniors, presents both an opportunity and a challenge, especially if the overall objective is to achieve Medicare savings.

Background

Medicare provides health insurance coverage for nearly one in six Americans, including 43 million seniors and 9 million younger adults with permanent disabilities. Many Medicare beneficiaries have significant medical needs and modest incomes (Exhibit 1). Four in ten beneficiaries live with three or more chronic conditions. About one in four beneficiaries is in fair or poor health and about the same share has a cognitive or mental impairment, such as Alzheimer's disease. More than half live on incomes of \$22,500 or less.



Medicare, at 16 percent of the federal budget, has been and continues to be a part of discussions to reduce government spending. Over the long term, the country faces very real challenges, with the retirement of the baby boom generation and rising health care costs (that will affect all payers). In the nearer term, Medicare spending is projected to grow at a substantially lower rate than it did in the past decade, at about the same rate as the economy, and at a slower rate than private insurance on a per person basis (Exhibit 2).



A wide range of proposals have been put forward to further slow the growth in Medicare spending that could potentially affect providers, plans, and beneficiaries, including options to simplify and restructure Medicare's current benefit design.¹

Benefits, Supplemental Coverage, and Out-of-Pocket Spending

Medicare today has a relatively complicated benefit structure, with Part A (primarily for inpatient hospital and post-acute care), Part B (for physician and other outpatient services) and now Part D (prescription drug coverage). Parts A, B and D each have their own deductibles (\$1,184 for Part A; \$147 for Part B; and \$325 for the standard Part D benefit) and varying levels of coinsurance or copayments, depending on the service (Exhibit 3). Unlike typical large employer plans, Medicare has no limit on out-of-pocket spending for inpatient and outpatient services covered under Parts A and B. Even with the addition of the drug benefit, Medicare remains less generous than the typical large employer preferred provider organization

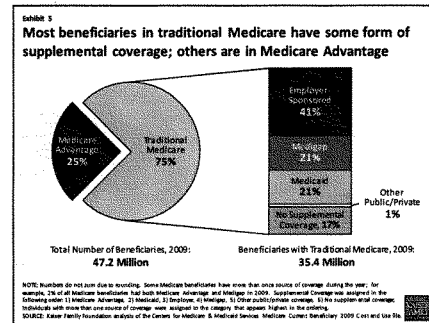
Table 3
Traditional Medicare has a fairly complicated benefit design and no limit on out-of-pocket spending

Part A	Part B	Part D
Deductible \$1,184 (out of pocket) Inpatient hospital No coinsurance, for days 1-60; \$296/day, for days 61-90; \$592/day, for days 91-120; No coverage after day 120 Skilled nursing facility No coinsurance, for days 1-30; \$148/day for days 31-100 Home health, hospice No coinsurance No limit on cost-sharing for Part A services	Deductible \$147 in 2013 Physician and other services 20% coinsurance Outpatient mental health 80% coinsurance Annual "wellness" visit, clinical laboratory services, home health care No coinsurance Preventive services No coinsurance for many services; 20% for some	Deductible \$325 in 2013 Initial coverage 25% coinsurance (up to \$2,970 in total drug costs) Coverage gap 47.5% coinsurance for brands; 78% coinsurance for generics between \$2,970 and \$6,975 in total drug costs Catastrophic coverage Minimum of \$2,600/year; \$6,900/brand, or 5% coinsurance above \$4,750 in out-of-pocket spending

(PPO) plan and the Blue Cross/Blue Shield Standard Option offered through the Federal Employees Health Benefits Program (also a PPO plan) (Exhibit 4).²

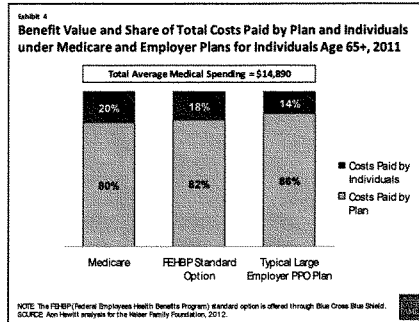
To help cover some or all of Medicare's cost-sharing requirements, and ease concerns about unpredictable medical bills, most beneficiaries in traditional Medicare have

supplemental coverage (Exhibit 5). Employer-sponsored plans (mainly for retirees) remain the primary source of supplemental coverage, providing additional coverage to 41 percent of



Medicare. Another 17 percent of all beneficiaries in the traditional Medicare program (12 percent of the total Medicare population) have no source of supplemental coverage. This includes a disproportionate share of beneficiaries with modest incomes, in fair or poor health, and younger beneficiaries with permanent disabilities.³ These beneficiaries would be fully exposed to higher deductibles and coinsurance requirements under many of the leading benefit redesign proposals.

A growing number of Medicare beneficiaries, now 27 percent, are covered by Medicare Advantage plans, rather than traditional Medicare. Medicare Advantage plans provide at least the same set of benefits as traditional Medicare, but do not typically have deductibles for services covered under



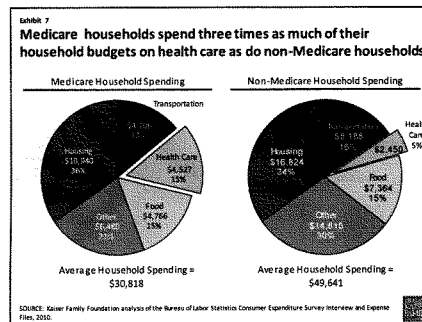
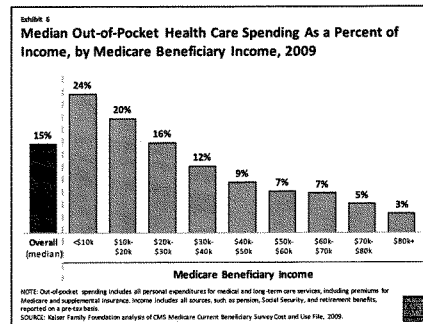
beneficiaries in traditional Medicare in 2009.

Another 21 percent of beneficiaries in traditional Medicare are covered by supplemental insurance policies, known as Medigap. Medicaid plays a key role for beneficiaries with low incomes and limited savings – providing wrap around coverage for 21 percent of beneficiaries in traditional

Parts A and B and now include limits on enrollees' out-of-pocket spending (not to exceed \$6,700 in 2013). Nearly half of all Medicare Advantage enrollees are in plans with limits at or below \$3,400.⁴

Out-of-Pocket Spending

But even with Medicare, and supplemental insurance, beneficiaries tend to have relatively high out-of-pocket health costs. In 2009, half of all Medicare beneficiaries spent 15 percent or



more of their income on health-related expenses – including premiums, cost sharing for Medicare-covered services, and services not covered by Medicare. Among those with incomes below \$20,000, the burden was even higher (Exhibit 6). Overall, Medicare households spend three times as much of their household budgets on health care as do non-Medicare households (Exhibit 7).

Proposals to Restructure the Medicare Benefit Design

A number of policymakers and other experts have proposed to simplify the Medicare benefit design, generally but not exclusively in the context of broader efforts to reduce Medicare and/or federal spending. Typically, these proposals focus on Medicare Parts A and B, but not Part D. Benefit redesign proposals can be, and have been, structured to strengthen or weaken the coverage provided to beneficiaries under traditional Medicare (or maintain the overall value of the benefit). They can also be designed to increase or decrease federal spending depending on the

benefit parameters, such as the level of the unified deductible and out-of-pocket spending limit, and the extent to which they incorporate financial protections for beneficiaries with low incomes.

In 2010, for example, the National Commission on Fiscal Responsibility and Reform proposed a restructured benefit design as part of a broader effort to reduce the national debt. The proposal would create a combined Part A and B deductible of \$550; a single 20 percent coinsurance rate for all Medicare-covered services; a five percent coinsurance rate for costs between \$5,550 and \$7,500; and an annual out-of-pocket maximum of \$7,500.⁵ The Congressional Budget Office (CBO) evaluated a similar option, and estimated federal savings of \$32 billion from 2012 to 2021.⁶

Some of the more recent proposals to restructure Medicare benefits are designed with the goal of maintaining aggregate cost-sharing requirements for beneficiaries. The Medicare Payment Advisory Commission (MedPAC) adopted this approach in their 2012 recommendation to add an out-of-pocket spending limit to traditional Medicare, replace current coinsurance rates with copayments to simplify payments for beneficiaries, and grant the Secretary of Health and Human Services the authority to make value-based changes to Medicare's benefit design.⁷ In 2013, the Bipartisan Policy Center Health Care Cost Containment Initiative (led by Alice Rivlin and former Senators Pete Domenici, Tom Daschle, and Bill Frist), proposed a benefit redesign as part of a broader set of recommendations to reduce health costs, that would also maintain aggregate beneficiary cost-sharing liabilities. In 2013, Erskine Bowles and Alan Simpson – who co-chaired of the 2010 National Commission on Fiscal Responsibility and Reform – made a similar recommendation that benefit redesign not affect average out-of-pocket costs (including premiums).

Some of the recent proposals would also strengthen financial protections for low-income Medicare beneficiaries. For example, the 2013 proposal from Erskine Bowles and Alan Simpson included an income-related out-of-pocket spending limit and a lower deductible for low-income beneficiaries – features that were not included in the recommendations issued by the Fiscal Commission in 2010. The 2013 Bipartisan Policy Proposal also proposed to strengthen

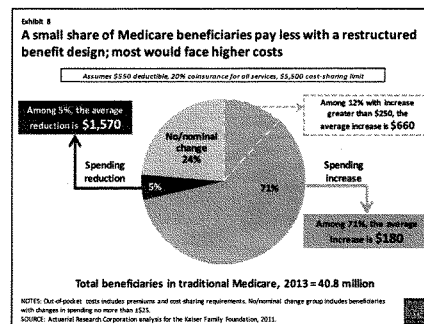
protections for low-income beneficiaries, by providing new federal assistance with Medicare's cost sharing to beneficiaries with incomes between 100 percent and 150 percent of the federal poverty level (with no asset test).

What are the Implications of a Restructured Benefit Design for Beneficiaries?

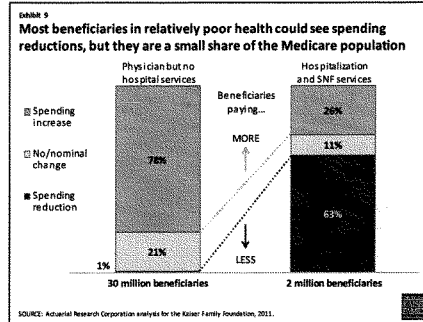
In November 2011, the Kaiser Family Foundation released a report that analyzed the distributional and cost implications of replacing Medicare's current benefit design with a unified deductible for Parts A and B of \$550; a 20 percent coinsurance for most Medicare-covered services; and a \$5,500 annual limit on out-of-pocket spending (the CBO Budget Option, which is similar to the 2010 Fiscal Commission recommendation).^{8,9} The analysis, conducted with researchers at Actuarial Research Corporation, assumes that the proposal was fully implemented in 2013. Variations on this basic option would produce different results for beneficiaries, other stakeholders, and Medicare expenditures.

Restructuring Medicare's cost-sharing requirements in such a fashion would be expected to raise costs for the majority of Medicare beneficiaries while reducing spending for some of the sickest. The effects for any given individual would depend on the particular mix of Medicare-covered services they need and their supplemental coverage.

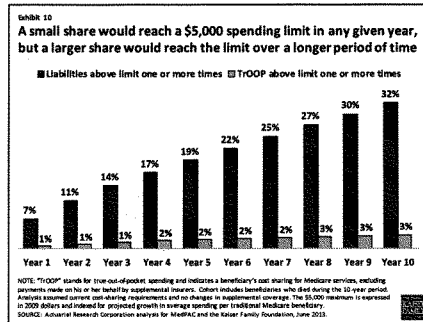
- **Five percent of beneficiaries in the traditional program (about 2 million) would be expected to see savings as a result of the changes, averaging \$1,570 in 2013 (Exhibit 8).¹⁰**



- Beneficiaries using inpatient hospital and post-acute care, for example, would be more likely to be helped by the alternative benefit design because they are more likely to incur costs that exceed the limit on out-of-pocket spending (Exhibit 9). In any given year, this group would represent a small share of the total Medicare population.



- Over a longer term, a larger percentage of beneficiaries would reach the out-of-pocket limit. MedPAC and the Kaiser Family Foundation recently contracted with the Actuarial Research Corporation to look at the share of Medicare beneficiaries expected to have cost-sharing liabilities above \$5,000 one or more times over a ten-year period. While only 6 to 7 percent of traditional Medicare beneficiaries would have cost-sharing liabilities that reach \$5,000 in one year, 32 percent would reach this amount at least once over a 10-year period (Exhibit 10).¹¹



- Not all beneficiaries with intensive service use would see a reduction in spending. Beneficiaries with expenses that do not exceed the out-of-pocket limit could end up paying substantially more for their Medicare-covered services due to the new 20 percent coinsurance for home health services and for relatively short inpatient hospital and skilled nursing facility stays (even with a lower Part A deductible).

- **Overall, 71 percent of beneficiaries in the traditional program (about 29 million beneficiaries) would be expected to see at least some increase in their out-of-pocket costs under the revamped system in a given year.**
 - For example, beneficiaries in relatively good health, who tend to have a few physician visits in a year but no inpatient care would be expected to have higher out-of-pocket costs, principally because they would face a unified deductible (\$550) that is more than three times more than their current law deductible (\$147 for Part B in 2013).
 - Five million beneficiaries would be expected to face an increase of \$250 or more in their out-of-pocket costs, averaging \$660 in 2013; more than one third of these beneficiaries have incomes between 100 and 200 percent of the federal poverty level, a group that is not generally eligible for cost-sharing assistance under Medicaid.

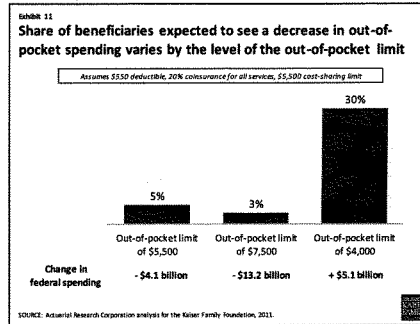
These changes to the benefit design would reduce Medicare spending by an estimated \$4.2 billion in 2013, according to our analysis, but aggregate spending among Medicare beneficiaries would rise by \$2.3 billion. The proposal would also be expected to result in higher costs for employers (\$0.6 billion), TRICARE (\$0.2 billion) and other payers (\$0.4 billion). Medicaid spending (federal and state combined) would decrease modestly by \$0.1 billion in 2013, mainly due to the limit on out-of-pocket spending. Taken together, the changes would result in a net reduction in total health care spending of less than \$1 billion in 2013.

Alternative Ways to Restructure the Benefit Design

Proposals to restructure the Medicare benefit design could be, and have been, modified in a number of ways to achieve different policy objectives. Such modifications include the following:

- **Raise or lower the out-of-pocket spending limit.** Proposals vary in the level at which the out-of-pocket limit for traditional Medicare is set. A lower limit would help more beneficiaries but erode Medicare savings, while the opposite is true for a higher limit. For example, if the CBO option were modified to include a lower \$4,000 spending limit, 30 percent of traditional

beneficiaries would be expected to see a spending reduction compared to 5 percent under the \$5,500 limit, but the benefit design would *increase* federal spending by \$5.1 billion compared to savings of \$4.1 billion under the \$5,500 limit. With a \$7,500 spending limit, 39 percent of beneficiaries in traditional Medicare would be expected to see costs increase by at least \$250, compared to 12 percent under the \$5,500 limit, although this option would also lead to much higher federal savings of \$13.2 billion in 2013 (Exhibit 11).



- **Apply the “true out-of-pocket” (TrOOP) concept to the annual spending limit.** If the TrOOP concept were applied, as it is under Part D, cost-sharing payments made by supplemental insurers on behalf of an enrollee would not count towards the beneficiary's spending limit. As a result, fewer beneficiaries would reach the spending limit in a given year. For example, MedPAC and the Kaiser Family Foundation contracted with the Actuarial Research Corporation and found that only three percent of beneficiaries would reach a TrOOP spending limit of \$5,000 at least once over a 10-year period – compared to 32 percent if all Medicare cost-sharing liabilities were taken into account – assuming no change in supplemental coverage (Exhibit 10).¹² Of course, beneficiaries may decide not to purchase supplemental coverage if a TrOOP concept were applied given the lower probability of reaching the TrOOP spending limit with such insurance. Applying TrOOP to the spending limit would be expected to increase Medicare savings, in part because fewer beneficiaries would reach the spending limit, but it would also reduce the value of the new Medicare spending limit for beneficiaries.

- **Raise or lower the A/B deductible or exempt physician visits from the deductible.**

Proposals also vary in the level of the deductible, entailing another tradeoff between Medicare savings and beneficiaries' cost-sharing obligations. A higher deductible would increase savings and shift costs onto beneficiaries, while a lower deductible would decrease savings but also reduce the share of beneficiaries spending more under a restructured benefit design. Similarly, exempting certain services from the deductible, such as physician visits, would minimize cost increases for relatively healthy beneficiaries, and address the concern that a higher A/B deductible would discourage seniors from seeking care from a physician, when needed. The 2013 proposal from the Bipartisan Policy Center included a \$500 deductible, but excluded physician office visits from the deductible.

- **Replace coinsurance rates with copayments.** Some proposals would include copayments (which are fixed amounts) rather than coinsurance (which varies based on the amount of the medical expense) in order to make the cost-sharing requirements easier for beneficiaries to understand. Copayments can also reduce the financial burden on beneficiaries, and can be structured to encourage "higher value" care or care provided in lower-cost settings. This approach was included in the 2012 MedPAC recommendation and in the 2013 Bipartisan Policy Center proposal.

- **Provide additional protections for low-income beneficiaries.** Benefit redesign proposals could also be designed to strengthen protections for low-income beneficiaries, both to address the well-documented financial burdens experienced by this population and to target resources where most needed. One approach for mitigating the effect on low-income beneficiaries would be to federalize cost-sharing assistance for individuals with incomes up to 150 percent of the federal poverty level, using the Part D Low-Income Subsidy (LIS) as a model. The Bipartisan Policy Center would federalize cost-sharing assistance for individuals with incomes between 100 percent to 150 percent of poverty. Adding low-income protections, however could erode expected federal savings or even lead to an increase federal spending, unless these additional costs are offset by other savings or revenue provisions.

An alternative approach would provide greater protections for lower-income beneficiaries (and less for higher-income beneficiaries) by establishing an income-related out-of-pocket spending limit or deductible. Instituting income-related cost-sharing requirements would necessitate a significant administrative effort on the part of Medicare and perhaps other payers, and could raise privacy concerns.

- **Apply the new benefit design prospectively.** Rather than restructure the benefit design in the near future, the redesign could roll out sometime in the future, and apply only to new beneficiaries. This approach would prevent current beneficiaries from seeing any changes in out-of-pocket spending (increases or decreases), but may also reduce Medicare savings in the ten-year budget window. Further, if applied only to new enrollees, this approach would require Medicare to administer two benefit designs: today's design for current beneficiaries and the restructured benefit design for future beneficiaries.

The Effects of Combining the Benefit Redesign with Restrictions on First Dollar Medigap Coverage

In addition to restructuring Medicare's benefit design, several recent proposals attempt to achieve greater federal savings by prohibiting or discouraging beneficiaries from purchasing supplemental coverage generally or "first-dollar" coverage more specifically. In 2011, CBO estimated that restricting Medigap coverage of the first \$550 of enrollees' cost-sharing requirements and limiting coverage to 50 percent of the next \$4,950 (with the plan paying any cost sharing above that amount) would have saved \$54 billion from 2012 to 2021 and that combining this policy with benefit redesign would have saved \$93 billion over the same budget window.

The 2010 National Commission on Fiscal Responsibility and Reform proposed a similar policy that would combine benefit redesign with restrictions on Medigap coverage (as well as TRICARE for Life, federal retiree, and private employer-provided retiree coverage).¹³ MedPAC also recommended a premium charge on supplemental coverage (including both Medigap and employer-sponsored plans) in conjunction with changes to the benefit design for traditional

Medicare.¹⁴ In his FY2014 Budget, President Obama proposed to increase Part B premiums for new enrollees who purchase “near first-dollar” Medigap coverage beginning in 2017, although he did not propose to fundamentally restructure the Medicare benefit design.¹⁵

Prohibiting first-dollar Medigap coverage in conjunction with a restructured benefit package would also create winners and losers, according to the 2011 Kaiser Family Foundation analysis, under a policy where Medigap policies are prohibited from covering the first \$550 in cost sharing and restricted from covering more than 50 percent of cost sharing above the deductible and up to the new spending limit, assuming full implementation in 2013.^{16,17}

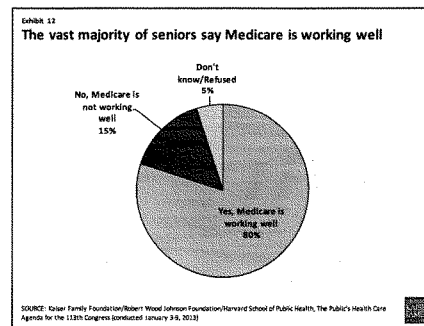
- **Half of all beneficiaries in traditional Medicare would be expected to see cost increases with Medigap restrictions and the A/B benefit redesign (less than the 71% with expected cost increases under the benefit redesign alone) and nearly a quarter (24%) would be expected to see costs decline (versus 5% with the benefit redesign alone).** This is a more favorable distribution than the benefit redesign alone because the Medigap restrictions are expected to reduce Medigap premiums (as plans would cover fewer expenses) and reduce Part B premiums because beneficiaries would be expected to use fewer Part B services when faced with higher cost-sharing requirements.
- **The combined benefit redesign and Medigap restrictions would nonetheless increase costs for an estimated six million Medicare beneficiaries by more than \$250, with an average increase of \$780 in 2013.** More than half of the beneficiaries in this group have incomes below 200 percent of the federal poverty level. Restricting Medigap coverage would require enrollees to pay a greater share of their medical expenses on their own, which would be especially burdensome for enrollees with large medical expenses. For many enrollees with one or more hospitalizations, for example, the increase in cost-sharing requirements would more than offset any reductions in Part B and supplemental premiums.

An alternative approach – a premium surcharge or excise tax on supplemental plans – could raise program revenues and achieve savings by discouraging some beneficiaries from purchasing supplemental coverage. With a surcharge approach, beneficiaries with modest means may be more likely to drop supplemental coverage if they are unable to afford the additional fee. Those who drop coverage would be expected to use fewer services as a result. Higher-income beneficiaries might be more likely to keep their supplemental coverage, in which case their premiums would increase but their use of care would likely be unaffected.

The primary justification for these proposals is the view that supplemental coverage, especially first-dollar coverage, drives up Medicare spending by insulating enrollees from the cost of the services they use.¹⁸ Numerous studies have demonstrated that increases in cost sharing result in decreases in utilization. However, the literature also confirms that people forego both necessary and unnecessary care, the former of which could lead to health complications and additional costs in the long run. Research also suggests that, while cost sharing may affect the decision of whether to seek care, it has a smaller impact on the intensity of care provided, and it may have a smaller impact on the use of certain services.¹⁹

Conclusion

Medicare today enjoys broad support among the public, and a large majority of seniors say the program is working well (Exhibit 12). Nonetheless, the current benefit design is relatively complicated and, unlike most employer plans, Medicare has no out-of-pocket limit for inpatient and outpatient services. Given Medicare's relatively high cost-sharing requirements, the majority of beneficiaries purchase some form of supplemental coverage.



Several benefit redesign proposals would provide real help to a small share of the Medicare population in a given year, while raising costs for many if not most beneficiaries – many of whom have modest incomes and devote a relatively large share of their incomes and household budgets towards health-related expenses. Some of the more recent proposals would provide additional protections for low-income beneficiaries – an important feature for minimizing the risk of shifting costs onto seniors living on fixed incomes. Finding an approach that will streamline benefits, coax beneficiaries toward high-value providers and services, provide greater protections to those with relatively high cost-sharing expenses and/or low incomes, all without shifting excessive costs onto seniors, is both an opportunity and a challenge, particularly in a deficit reduction context.

¹ Kaiser Family Foundation, *Medicare and the Federal Budget: Comparison of Medicare Provisions in Recent Federal Debt and Deficit Reduction Proposals*, June 2013, available at: <http://www.kff.org/medicare/issue-brief/medicare-and-the-federal-budget-comparison-of-medicare-provisions-in-recent-federal-debt-and-deficit-reduction-proposals/>; Kaiser Family Foundation, *Policy Options to Sustain Medicare for the Future*, January 2013, available at: <http://www.kff.org/medicare/report/policy-options-to-sustain-medicare-for-the-future/>.

² Kaiser Family Foundation, *How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?: A 2012 Update*, April 2012, available at: <http://www.kff.org/health-reform/issue-brief/how-does-the-benefit-value-of-medicare/>.

³ Kaiser Family Foundation, *Examining Sources of Supplemental Insurance and Prescription Drug Coverage Among Medicare Beneficiaries: Findings from the Medicare Current Beneficiary Survey, 2007*, August 2009, available at: <http://www.kff.org/medicare/report/examining-sources-of-supplemental-insurance-and-prescription/>.

⁴ Kaiser Family Foundation, *Medicare Advantage 2013 Spotlight: Enrollment Market Update*, June 2013, available at: <http://www.kff.org/medicare/issue-brief/medicare-advantage-2013-spotlight-enrollment-market-update/>.

⁵ The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, available at: <http://www.fiscalcommission.gov/news/moment-truth-report-national-commission-fiscal-responsibility-and-reform>.

⁶ Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options*, March 2011, available at: <http://www.cbo.gov/publication/22043>.

⁷ MedPAC also recommended placing a surcharge on supplemental plans, including Medigap and employer-sponsored retiree plans. While MedPAC recommended these broad features of a new benefit design, they did not suggest specific parameters (such as specific copayment amounts). Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*, June 2012, available at: http://www.medpac.gov/documents/jun12_EntireReport.pdf.

⁸ Kaiser Family Foundation, *Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending*, November 2011, available at: <http://www.kff.org/medicare/report/restructuring-medicare-benefit-design/>.

⁹ Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options*, March 2011, available at: <http://www.cbo.gov/publication/22043>. The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, available at: <http://www.fiscalcommission.gov/news/moment-truth-report-national-commission-fiscal-responsibility-and-reform>.

¹⁰ Our analysis only defines beneficiaries with increases or decreases in out-of-pocket spending as those with changes in spending of \$25 or more.

¹¹ Medicare Payment Advisory Commission and Kaiser Family Foundation, *An Analysis of the Share of Medicare Beneficiaries Who Would Benefit from an Annual Out-of-Pocket Maximum under Traditional Medicare Over Multiple Years*, June 2013, available at: <http://www.kff.org/medicare/issue-brief/analysis-of-share-of-medicare-beneficiaries-who-would-benefit-from-out-of-pocket-maximum-over-multiple-years/>.

¹² Medicare Payment Advisory Commission and Kaiser Family Foundation, *An Analysis of the Share of Medicare Beneficiaries Who Would Benefit from an Annual Out-of-Pocket Maximum under Traditional Medicare Over Multiple Years*, June 2013, available at: <http://www.kff.org/medicare/issue-brief/analysis-of-share-of-medicare-beneficiaries-who-would-benefit-from-out-of-pocket-maximum-over-multiple-years/>.

¹³ The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, available at: <http://www.fiscalcommission.gov/news/moment-truth-report-national-commission-fiscal-responsibility-and-reform>.

¹⁴ Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*, June 2012, available at: http://www.medpac.gov/documents/jun12_EntireReport.pdf.

¹⁵ Office of Management and Budget, *Fiscal Year 2014 Budget of the U.S. Government*, April 2013, available at: <http://www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/budget.pdf>.

¹⁶ Kaiser Family Foundation, *Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending*, November 2011, available at: <http://www.kff.org/medicare/report/restructuring-medicare-benefit-design/>.

¹⁷ The Kaiser Family Foundation also analyzed the impact of Medigap restrictions independent of benefit redesign: Kaiser Family Foundation, *Medigap Reforms: Potential Effects of Benefit Restrictions on Medicare Spending and Beneficiary Costs*, July 2011, available at: <http://www.kff.org/medicare/report/potential-effects-of-medigap-reforms/>.

¹⁸ As an example of research exploring the impact of supplemental coverage on Medicare spending, see: Christopher Hogan, *Exploring the Effects of Secondary Coverage on Medicare Spending for the Elderly*, June 2009, available at: http://www.medpac.gov/documents/jun09_SecondaryInsurance_CONTRACTOR_RS_REVISED.pdf. MedPAC also provides a summary of other research on this subject: Medicare Payment Advisory Commission. *Report to the Congress: Medicare and the Health Care Delivery System*, June 2012, available at: http://www.medpac.gov/documents/jun12_EntireReport.pdf.

¹⁹ Katherine Swartz, *Cost-Sharing: Effects on Spending and Outcomes*, December 2010, available at: <http://www.rwjf.org/content/rwif/en/research-publications/find-rwif-research/2011/12/cost-sharing-effects-on-spending-and-outcomes.html> and Mathematica Policy Research, *Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature*, March 2006, available at <http://www.mathematica-mpr.com/publications/pdfs/priceincome.pdf>.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman, Mr. Miller, 5 minutes for an opening statement.

STATEMENT OF THOMAS MILLER

Mr. MILLER. Thank you, Chairman Pitts, Ranking Member Pallone and members of the subcommittee for the opportunity to speak this morning on redesign of Medicare's outdated benefit structure.

Restructuring the splintered cost-sharing requirements of the traditional Medicare fee-for-service program, separate silos for Part A and B if not D, provides a potential policy reform tool that could achieve the twin goals of saving taxpayer dollars while improving the most essential risk protection benefits for elderly beneficiaries.

By increasing Medicare enrollees' cost consciousness regarding more disciplinary initial dollar health care choices, a coordinated set of changes in traditional Medicare's deductible and coinsurance provisions could help reduce current and future levels of Medicare spending. Some of those savings from increased cost sharing at the front end of Medicare coverage then could be used to provide better stop-loss protection against larger catastrophic risks as well as to substantially limit if not eliminate the need and demand for supplemental insurance that imposes excess costs on basic Medicare coverage.

However, these fiscal and risk protection benefits must compete with and can complement other policy considerations. They include improved integration of health care delivery, realigned incentives to improve value-based health care, more effective competition between traditional Medicare and private Medicare Advantage plans, and continued protection of the most vulnerable low-income beneficiaries, and this complex balancing act, hard enough in theory, must remain administratively feasible in practice.

A number of cost-sharing reform proposals in recent years hit one or more of those target objectives to varying degrees. My written testimony suggests some different ways to set clear policy priorities, accommodate necessary exceptions, and still maneuver through the complexities of implementation and administration.

To summarize, traditional Medicare remains a largely unmanaged fee-for-service program that needs to rely on increased but more coherent cost sharing as an important tool though not the only one to help control its excess costs. Hence, overcoming the political cross-pressures that resist any such changes must be worth the trouble by producing significant net budget savings rather than a budget-neutral rearrangement of the chairs on the spending deck.

The highest priority should be to protect all seniors against health-related financial risks that they cannot bear on their own. That is not equivalent to hiding from them as many health care costs as possible through third-party payments. Such stop-loss protection, predominant in private insurance plans for decades, is long overdue for traditional Medicare, but in this case, it should be income related rather than set as the same dollar amount for every beneficiary. This major risk approach to Medicare cost sharing should consider the alternative of relying more on a higher rate of coinsurance across a wider range of initial health spending and less on deductibles and lump-sum amounts. This would extend the cor-

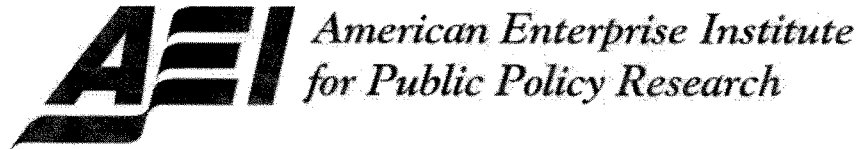
ridor of cost sensitivity and engage more Medicare beneficiaries in monitoring the real costs of their subsidized care yet temper the full impact of cost sharing in deciding whether to seek any care at all. Amounts of coinsurance-based cost sharing also reset automatically as health care costs rise, and hopefully fall someday.

The cleaner and less complicated way to deal with the distortions of supplemental insurance for traditional Medicare enrollees is to improve that program's basic risk protection directly and then set regulatory boundaries on what either individual Medigap plans or employer-sponsored retiree plans can cover. We don't need another new tax on those plans piled on top of the existing debris of dead-weight distortions throughout the tax code. Let us subsidize non-poor seniors less instead of taxing them more.

Of course, the poorest seniors must continue to receive special protection against health care cost burdens. Supplemental Medicaid coverage for dual-eligibles would remain in place. More attention should be paid to restructuring current Medicare savings programs for other low-income seniors in a better integrated manner, and in some cases, supplementing them, particularly for those facing high cost conditions. Evidence-based preventive health benefits also should be exempted from expanded cost sharing. Efforts to improve health information and navigational assistance for all beneficiaries but particularly those with cognitive impairments need much more attention and budget support.

The particular parameters for restructured cost sharing suggested in my written testimony are merely suggestive starting points but they can help lead us to a reformed Medicare program that relies more on income-related cost-consciousness, enhances true insurance protection against catastrophic risks, and reduces the likelihood of rising premiums, steeper taxes and hidden benefit cuts.

Thank you. I look forward to your questions.
[The prepared statement of Mr. Miller follows:]



Statement before the House Committee on Energy and Commerce

Subcommittee on Health Hearing

A 21st Century Medicare:

Bipartisan Proposals to Redesign the Program's Outdated Benefit Structure

Bigger Steps Needed for Medicare Cost-Sharing Reform

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June 26, 2013

Summary Points

- Slowing the future rate of Medicare spending to below its currently projected baseline level should be the primary reason for reforming the structure of cost sharing in the traditional Medicare program.
- A major-risk approach to cost sharing, with higher coinsurance and annual stop-loss caps tied to income level, could provide the fairest and most effective avenue toward the best results.
- Taxes on Medigap coverage just complicate the tax code more without much precision in retargeting Medicare spending incentives; instead, higher-income seniors should be subsidized less and low-income seniors subsidized more.
- Modernization of Medicare cost sharing could improve integration of health care delivery, realign incentives to improve value-based health care, protect beneficiaries against catastrophic health risks, and facilitate more effective competition between traditional Medicare and private Medicare Advantage plans
- Changes in cost sharing must continue to protect vulnerable low-income beneficiaries and remain administratively feasible.

Thank you Chairman Pitts, Ranking member Pallone, and members of the Subcommittee on Health for the opportunity to testify today on redesigning Medicare's outdated benefit structure, particularly its provisions for cost sharing.

I am testifying today as a health policy researcher and a resident fellow at the American Enterprise Institute (AEI). I also will draw upon previous experience as a senior health economist at the Joint Economic Committee, member of the National Advisory Council for the Agency for Healthcare Research and Quality, and health policy researcher at several other Washington-based research organizations.

Finding economically feasible and politically tenable options for slowing the rate of spending growth in Medicare through restructured cost sharing -- without harming the quality of care delivered or jeopardizing vulnerable beneficiaries -- has proven to be no easy task. A variety of government organizations, including the Congressional Budget Office and Medicare Payment Advisory Commission, and academic health policy researchers have put forth recent plans to improve the program, but they often diminish potential savings by playing it too safe. The best option for sustainable reform that balances a number of competing policy considerations appears to be a major-risk approach toward restructuring

cost-sharing requirements for the traditional Medicare program. It involves a higher coinsurance rate and a stop-loss income-related cap on participants' annual cost-sharing liabilities. An additional key to subsidizing high-income seniors less is by restricting their use of supplemental insurance such as Medigap for early-dollar spending, rather than taxing the coverage itself.

When health policy analysts join forces with budget-deficit hawks to search for remaining targets of belt-tightening in the Medicare program, they usually find that the policy reform shelves are relatively bare of politically "safe" options that can deliver early and significant cost savings.

Most premium support proposals generally would delay their implementation for at least a decade, and they stop short of seriously threatening the longevity of the traditional Medicare fee-for-service (FFS) program. Although the Affordable Care Act (ACA) relies heavily on annual, across-the-board reimbursement cuts for health care providers, the sustainability of its budgetary formulas that would eventually drive some Medicare payments down to below-cost Medicaid levels remains dubious. Raising the eligibility age for Medicare benefits in the near term also seems ahead of its time.

Repeatable and scalable results from a host of fiscal-science-fair demonstration projects in the ACA are always somewhere over the budget

window's horizon. And the ability of pioneering accountable care organizations to breed in the regulatory captivity of Obamacare will require heroic assumptions about either asexual reproduction or politically assisted artificial insemination.

However, restructuring the splintered cost-sharing requirements of the traditional Medicare FFS program's separate silos for parts A and B (if not part D)¹ provides another potential policy reform tool that could achieve the twin goals of saving taxpayer dollars while improving risk-protection benefits for elderly beneficiaries. By increasing Medicare enrollees' cost consciousness regarding more discretionary, first-dollar health care choices,² a coordinated set of changes in the traditional program's deductible and coinsurance provisions could help reduce current and future levels of Medicare spending. At least some of those savings from greater sharing of health care costs between Medicare insurance benefits and enrollee's out-of-pocket payments at the front end could be used to provide better "stop-loss" protection against larger catastrophic risks.

My testimony today is going to focus primarily on *how* policymakers might restructure traditional Medicare cost sharing to achieve these goals, and less on the lively debate that continues over *whether* they should do so. Regarding the latter issue, the arguments for cost sharing reform within the

traditional menu of benefits within Medicare FFS usually first point to the higher discretionary spending that its relatively low deductibles produce, particularly when augmented by additional layers of supplemental insurance coverage (such as individual Medigap insurance, employer-sponsored retiree coverage, and Medicaid). Past research studies differ in the magnitude of this effect, but they generally agree on its direction.³ Most recently, a MedPAC-sponsored study concluded that total Medicare spending was 33 percent higher for beneficiaries with Medigap policies than for those with no supplemental coverage. For beneficiaries with employer-sponsored supplemental coverage, Medicare spending was 17 percent higher.⁴

Although such potential budgetary savings generally provide the strongest political rationale for Medicare cost-sharing reform, they must compete with and complement other policy considerations. Modernization of Medicare cost sharing could improve integration of health care delivery, realign incentives to improve value-based health care, protect beneficiaries against catastrophic health risks, and facilitate more effective competition between traditional Medicare and private Medicare Advantage plans. At the same time, changes in cost sharing must continue to protect vulnerable low-income beneficiaries and remain administratively feasible.

Past Proposals to Restructure Medicare Cost Sharing

Proposals for reform of Medicare cost sharing are far from virgin territory in health policy circles. The historical legacy of Medicare's original division between hospital-based care and other outpatient care (with two separate trust funds and sources of financing) has produced substantial initial cost sharing for the first day of hospital care in the form of a high deductible (\$1,184 in 2013) in Part A, but a much lower deductible (\$147 in 2013) for outpatient services spending in Part B.

However, coinsurance cost sharing of 20 percent for each additional dollar of Part B outpatient care above that program's initial deductible amount is not capped, and it could potentially amount to even greater out-of-pocket liabilities for beneficiaries. For example, 6 percent of Medicare fee-for-service beneficiaries who enrolled in Part A and Part B for 12 months in 2009 had a cost-sharing liability of \$5,000 or more (assuming no additional insurance coverage, such as an individual Medigap plan, employer-sponsored retiree coverage, or Medicaid supplemental benefits for low-income retirees).⁵ Moreover, the probability of catastrophic health spending over time is higher than the probability within a single year would indicate.⁶

Hence, a majority of the members of the National Bipartisan Commission on the Future of Medicare in 1999 recommended that the

separate deductibles for Part A and Part B be replaced with a single deductible of \$400, which then would be indexed to growth in Medicare costs.⁷

In March 2011, the Congressional Budget Office (CBO) analyzed the effects of replacing Medicare's mix of cost-sharing requirements with a single combined deductible of \$550 (covering all Part A and Part B services), a uniform coinsurance rate of 20 percent for amounts above that deductible, and an annual cap of \$5,500 on each enrollee's total cost-sharing liabilities. CBO estimated that if this option took effect on January 1, 2013, with the various thresholds indexed to growth in per capita Medicare costs in later years, federal spending for Medicare would fall by about \$32 billion over the 2012–21 period.⁸

Limiting the Spillover Spending Effects of Supplemental Coverage

If Medigap plans—private plans designed to supplement basic Medicare coverage and sold to individuals—were barred from paying the first \$550 of an enrollee's cost-sharing liabilities for calendar year 2013 and could cover only half of other Medicare cost sharing (equivalent to changing Part B's 20-percent coinsurance rate to only 10 percent) up to the annual \$5,500 cap on total cost sharing (and if the various thresholds were indexed to growth in per-capita Medicare costs for later years), CBO estimated that,

under this reform option, projected federal outlays would be reduced by roughly \$93 billion over the 2012–21 period.⁹

MedPAC Leaves More Restructuring Discretion to HHS Secretary

In June 2012, the Medicare Payment Advisory Commission (MedPAC) proposed a slightly different approach to reform Medicare's benefit design. It recommended an annual deductible for Part A and Part B services equaling \$500 (while leaving open whether it would be combined or separate for those categories). However, MedPAC suggested that copayments (fixed dollar amounts), rather than coinsurance (a percentage of costs), should apply for cost sharing above the deductible amount and until a total annual, out-of-pocket \$5,000 maximum is reached.¹⁰ It further complicated and diluted the effects of this restructuring by insisting that beneficiaries' cost-sharing liabilities in the aggregate should not increase in the redesign of the traditional Medicare fee-for-service program. MedPAC also proposed that copayment amounts may vary by type of service and provider, with the secretary of health and human services altering or eliminating cost sharing based on evidence of the value of particular services.¹¹

MedPAC took a sizable leap of faith that the likely evidence base will be sufficiently robust for the secretary to tailor cost sharing in an accurate

and consistent manner. The Medicare advisory body then urged a different “tax” approach to discourage, or at least recoup, some of the added costs imposed on the basic Medicare program when supplemental Medigap coverage encourages greater spending. Instead of relying solely on barring Medigap insurers from paying any of the initial costs falling within the unified deductible and then limiting reductions in coinsurance liabilities above that amount to no more than half the standard 20-percent rate for Part B spending, MedPAC would allow beneficiaries the option to add costs to this (newly restructured) basic Medicare coverage through additional Medigap insurance. But they then would be charged for exercising this privilege with an extra 20-percent “excise tax” on the value of that supplemental coverage.¹²

The actual effects of this change in the treatment of supplemental Medicare coverage¹³ would vary depending on the degree to which beneficiaries choose to retain their additional coverage and pay the tax (producing new revenue to offset some of the higher Medicare spending), as opposed to dropping that coverage and creating more budget savings through lower Medicare spending.

Adjusting Cost Sharing for the Income Levels and Health Risks of Beneficiaries?

Earlier this year, MIT economist Jonathan Gruber proposed a plan for restructuring cost sharing and supplemental insurance for Medicare, as part of the Brookings Institution's *15 Ways to Rethink the Federal Budget*. He expressed concern with the affordability of revisions to cost sharing among seniors under some of the previous reform proposals, as well how proposed stringent regulation on supplemental Medicare plans would not allow the plans to "reflect diversity of elders' tastes for supplemental coverage."¹⁴

Gruber proposed an alternative to previous CBO proposals, based instead on an "income-related" out-of-pocket maximum. Gruber divides those stop-loss limits into just four income categories and then sets their maximums as respective fractions (1/3, 1/2, 2/3, and all) of the current-law health savings account stop-loss limit (\$5,950) that also is used under the Affordable Care Act's rules for qualified insurance coverage. He also recommends reducing the unified deductible by half (to \$250) for seniors below 200 percent of the federal poverty level.¹⁵

Gruber concedes that computing the amounts of such out-of-pocket protections will be administratively difficult and could raise privacy concerns if private insurers must know the incomes of individual Medicare

beneficiaries. The greater irony is that Gruber admits that his plan to protect low-income seniors by lowering their income-related, out-of-pocket maximums “by itself is unlikely to produce any budget savings.”¹⁶

To retrieve those dollars for the federal Treasury, Gruber proposes a tax on supplemental Medicare coverage—even higher than the one envisioned by MedPAC—to offset the higher Medicare spending that supplemental coverage causes. Subject to political negotiations, he estimates that a tax rate of up to 45 percent on Medigap plan premiums and on the cost of employer-sponsored retiree coverage would be justified.¹⁷ Gruber concludes that the budgetary implications of this proposal are “difficult to infer.”¹⁸

In an earlier *American Economic Review* study in 2010 with coauthors Amitabh Chandra and Robin McKnight,¹⁹ Gruber recommended that increased cost sharing should be tied to a patient’s underlying health status (rather than just income), with chronically ill patients facing lower cost sharing. The authors found that higher copayments for office visits and prescription drugs reduced Medicare medical spending, with elasticities of demand similar to those reported in the RAND Health Insurance Experiment²⁰ for the nonelderly. However, Chandra, McKnight, and Gruber also noted a significant offsetting rise in use of hospital care visits and

overall hospital-based spending (reducing net budget savings from higher copayments on other services by about 20 percent) because of the higher copayments for outpatient care and prescription drugs. Moreover, they found large offsets for the sickest Medicare populations with chronic diseases, suggesting that higher copayments for that cohort of beneficiaries produced little net budgetary savings for the Medicare program.²¹

Hence, Gruber and his coauthors concluded that because the “mirror effect” of this relationship suggests that an *increase* in physician and drug spending arising from supplemental Medicare coverage is substantially offset (within the traditional Medicare program) by the *fall* in hospital costs, income-related out-of-pocket limits alone provide far-from-optimal health insurance (and Medicare cost savings). They recommend further specific targeting of copayments related to the underlying health status of chronically ill patients.²²

Keeping Cost-Sharing Reform Simpler and More Effective

In any case, there is a better way to handle income-related limits on more unified Medicare cost sharing, again courtesy of a younger but wiser Jonathan Gruber. In 1994, Gruber and coauthor Martin Feldstein proposed “A Major Risk Approach to Health Insurance Reform.”²³ To reduce the economic dead-weight loss produced when low coinsurance rates (and low

marginal costs of insured care) induce excessive consumption of health care and inefficient resource allocation, Gruber and Feldstein modeled a different type of health insurance plan. It would have a 50-percent coinsurance rate but limit out-of-pocket health spending to 10 percent of income.

They estimated that aggregate welfare gains (which also include reduced risk bearing for large health care costs) by switching to major-risk insurance for both private and public (Medicare and Medicaid) health coverage would range from \$34 billion to \$110 billion—in 1995 dollars.²⁴ Those estimates varied depending on the degree of risk aversion and price elasticity of demand, respectively, by health care consumers. For example, a higher degree of risk aversion and higher demand elasticity would produce a larger welfare gain.

An attractive dimension of the major-risk approach is its relative progressivity. Average out-of-pocket spending under the plan rises sharply as income rises because the stop-loss maximum rises with income. The major-risk plan reduces the total consumption of health care much more for high-income individuals. It also alters the risk distribution individuals face by increasing the risk of modest spending but limiting the maximum risk.

Gruber and Feldstein noted that relying on 50-percent coinsurance, rather than the equivalent amount of cost sharing (up to 10 percent of

income) solely through a first-dollar deductible, extends the ability of the plan's cost-sharing incentives to reduce dead-weight losses across a wider range of health spending. But it also limits the value of the increased risk to individuals through greater cost sharing. Of course, the various specific projections of welfare-gain effects in the 1994 study would need to be updated to align with current levels of health spending, and they remain sensitive to relative assumptions about the levels of demand elasticity and risk aversion for health care consumers.

Policy Priorities for Reform

The larger lesson from these analyses of Medicare cost-sharing restructuring involves the importance of setting clear policy priorities, avoiding trying to accomplish conflicting goals with the same policy instrument, and carrying out first what matters most.

Slowing the future rate of Medicare spending to below its currently projected baseline level should be the primary reason for reforming the structure of cost sharing in the traditional Medicare program. That means most beneficiaries (except for those provided separate special protection from this reform) will actually end up receiving lower levels of taxpayer subsidies and either pay more for the Medicare services they want or get fewer (or less expensive) services. The most appropriate area of Medicare

spending to face those new cost-sharing incentives involves early-dollar, discretionary spending, rather than the costs facing beneficiaries with much more expensive or chronic medical conditions.

The major-risk approach to Medicare reform makes the most sense for most beneficiaries. It balances protecting them more effectively against catastrophic financial risks with increasing their cost consciousness for decisions involving health care costs they can manage better within the limits of their income. By relying on a higher percentage of coinsurance (rather than a large front-end deductible), this approach also produces the best mix of stop-loss protection and greater sensitivity to the non-catastrophic costs of covered services.

Maneuvering through Exceptions and Implementation

Trying to overcompensate and dilute the tension between most beneficiaries' income constraints (including the opportunity cost of spending for other non-health-care wants and needs) and their initial layers of health care need is likely to undermine the main purpose for taking on the difficult political challenge of increasing cost sharing for the traditional Medicare program. Nevertheless, it would prove to be too economically harsh and politically disastrous to ignore the need for at least some enhanced

protection of many lower-income Medicare beneficiaries within a higher cost-sharing approach.

Implementing a Medicare policy change of this magnitude also poses significant challenges. A new cost-sharing structure must remain understandable and workable in practice. It has to be sensitive to differences among beneficiaries but avoid trying to be customized to such a granular level that it cannot provide predictable incentives or support everyday billing and payment operations. Focusing cost-sharing reform on Medicare FFS also must account for keeping the future playing field as level as possible in the traditional program's competition with Medicare Advantage plans in attracting and retaining enrollees.

The administrative complexities of income-related cost sharing can be managed through setting a reasonable range of annual income bands linked to proportionately related mixes of out-of-pocket maximum levels (rather than calculating them dollar for dollar at every level of reported income).²⁵ This should be supplemented with a narrow set of opportunities to appeal for exceptions based on unexpected hardship.

The cleaner and less complicated way to deal with the distortions of supplemental insurance for traditional Medicare enrollees is to set regulatory boundaries on what either individual Medigap plans or employer-sponsored

retiree plans can cover.²⁶ The current tax code already produces enough distortions in economic decision making without adding a new excise tax on supplemental insurance premiums to that list.²⁷ Instead of taxing a small slice of affluent seniors *more* and then recycling some of that revenue back to other lower-income seniors (with all the inefficient processing and extraction charges this political spin cycle entails), it would be far better simply to subsidize nonpoor seniors *less*.

We should acknowledge the relationship between personal income and the ability to handle much greater cost sharing for health care services,²⁸ but respond by developing a separate program of cash subsidies to lower-income Medicare beneficiaries facing more chronic health conditions. Such financial assistance could be distributed directly to their (new) individual Medicare savings accounts based on a combination of their income and health risk scores. An alternative option would restructure and streamline current Medicare Savings Programs for low-income Medicare beneficiaries to match a more unified set of cost-sharing provisions in Medicare FFS.²⁹

Although such subsidies should be carefully targeted to be most generous to beneficiaries with the lowest incomes and the greatest health risks, their exact size and scope also should be related to the budget savings and cost-conscious economizing incentives that policymakers seek. Pushing

back on one end of the cost-sharing continuum would need to be balanced by increased cost sharing for higher-income and lower-risk beneficiaries. Although using an income-related stop loss limit on Medicare FFS cost sharing helps keep a beneficiary's out-of-pocket financial burden proportional to his or her income, it may be necessary to extend some additional, lesser amounts of cost sharing subsidies even to some beneficiaries with incomes somewhat above the dual-eligibility level for Medicaid.

The distortions of supplemental insurance coverage primarily harm the traditional Medicare FFS program, whether they originate from individual Medigap plans or employer-sponsored retiree coverage. These cost-sharing reforms are not needed for private plans in Medicare Advantage because the coverage scheme in those plans is integrated within a single insurer rather than spread across a taxpayer-financed primary insurer (traditional Medicare) and a secondary private insurer. To the extent that some further adjustments in cost-sharing rules for Medicare Advantage plans still may be needed for their annual competitive bidding process, they could be handled by using an actuarial equivalence standard that allows them to offer different cost-sharing packages (similar to how past and present Part D

prescription drug plans have varied so widely from the original statutory benefit defined in the Medicare Modernization Act).

Any remaining problems of mixed cost-sharing incentives and competitive effects could be corrected in two ways: (1) Require private insurers to offer only integrated coverage (current-law Medicare benefits plus any supplemental ones), with a separate price and taxpayer subsidies for the basic Medicare coverage, or its actuarial equivalent, determined through premium-support-style competitive bidding,³⁰ and (2) Authorize the traditional Medicare program greater administrative flexibility needed to compete in such a bidding regime, such as by offering more enhanced catastrophic stop-loss protection and changing other cost-sharing provisions to offset its budgetary costs.³¹

Given the future budgetary stresses and broader sustainability challenges facing the Medicare program, this more aggressive approach to reform its cost sharing is long overdue. But taking two modest, but important, steps forward—a unified deductible and a stop-loss limit for traditional Medicare—will provide little progress if we then take two steps backward—diluting such cost sharing for most Medicare beneficiaries on the unbounded assumption that very few may be able to afford it (or that too many then would refrain from seeking necessary health care services), and

instead adding a new tax at a fill-in-the-blank rate on supplemental insurance plan coverage.

The 1984 Walter Mondale presidential campaign once was tagged with an uninspiring, but telling, slogan for such tactics: “Dares to be cautious.”³²

The cost-saving juice must be worth the political squeeze in undertaking reform of Medicare cost sharing. A major-risk approach to reform of cost-sharing and taxpayer subsidies for coverage offers more future reward, whether for just Medicare or also the rest of the private health insurance market (as Feldstein and Gruber originally proposed).

The particular parameters for restructured cost sharing suggested in my testimony, of course, are merely suggestive markers rather than fixed points. They can be adjusted higher or lower, depending on the full mix of competing policy priorities and budgetary saving score that is desired. But they all will operate within a reformed Medicare FFS program that relies more on income-related cost-consciousness, enhances insurance protection against catastrophic risks, and reduces the likelihood of rising premiums and steeper taxes.

Notes

¹ Part A for Medicare covers the costs of inpatient care (primarily hospital spending). Part B covers physicians' services and other outpatient care. Part D covers prescription drug expenses. Each part of the traditional Medicare program has its own sources of financing (a payroll tax for Part A, separate enrollee premiums plus general revenue support for Parts B and D).

² Such discretionary spending decisions may involve either purchases within the scope and scale of first-dollar deductibles or other purchases subject to cost-sharing (either coinsurance or copayments) before any stop-loss limit on out-of-pocket spending is reached.

³ See, for example, Adam Atherly, "Supplemental Insurance: Medicare's Accidental Stepchild," *Medical Care Research and Review* 58, no. 2 (2001): 131-161; Sandra Christensen and Judith Shinogle, "Effects of Supplemental Coverage on Use of Services by Medicare Enrollees," *Health Care Financing Review* 19, no. 1 (1997): 5-17.

⁴ Christopher Hogan, "Exploring the Effects of Secondary Insurance on Medicare Spending for the Elderly," A Study Conducted by Staff from Direct Research, LLC, for MedPAC, 2009.

⁵ Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare and the Health Care Delivery System* (Washington, DC, June 2012), 5.

⁶ *Ibid.*, 10.

⁷ National Bipartisan Commission on the Future of Medicare, *Building a Better Medicare for Today and Tomorrow* (Washington, DC, March 16, 1999).

⁸ Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options* (Washington, DC, March 10, 2011): 49.

⁹ *Ibid.*, 49-50.

¹⁰ MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*, 20.

¹¹ *Ibid.*, 19.

¹² *Ibid.*, 21.

¹³ MedPAC would also apply the same reform to employer-sponsored retiree coverage.

¹⁴ Jonathan Gruber, "Proposal 3: Restructuring Cost Sharing and Supplemental Insurance for Medicare," in *15 Ways to Rethink the Federal Budget*, ed. Michael Greenstone et al. (Washington, DC: Brookings Institution, February 2013), 25.

¹⁵ *Ibid.*, 25.

¹⁶ *Ibid.*

¹⁷ *Ibid.*, 25-26.

¹⁸ *Ibid.*, 26.

¹⁹ Amitabh Chandra, Jonathan Gruber, and Robin McKnight, "Patient Cost-Sharing and Hospitalization Offsets in the Elderly," *The American Economic Review* 100, no. 1 (2010): 193-213.

²⁰ The RAND Health Insurance Experiment (HIE) remains the most extensive and important experimental study of the effects of cost-sharing and the design of health insurance benefits. Its results demonstrated that higher patient payments (cost sharing) significantly reduced use of medical care, without any adverse health outcomes for the average person. See, for example, Joseph Newhouse. *Free for All: Lessons from the RAND Health Insurance Experiment*. (Cambridge, MA: Harvard University Press, 1993).

²¹ Amitabh Chandra, Johnathan Gruber, and Robin McKnight, "Patient Cost-Sharing and Hospitalization Offsets in the Elderly," 209-11.

²² *Ibid.*, 212.

²³ Martin Feldstein and Jonathan Gruber, "A Major Risk Approach to Health Insurance Reform" (working paper 4852, National Bureau of Economic Research, Cambridge, MA, September 1994).

²⁴ *Ibid.*, 26. A full and accurate update, in terms of current (2013) dollars is not readily available, because it involves more variables than simply the effects of health care spending inflation over time.

²⁵ This involves balancing the unworkability of administering customized "personal" cost sharing limits for literally millions of Medicare beneficiaries against dilution of relatively income-sensitive variations in cost sharing, as well as treating seniors with significantly different incomes too similarly. The issue comes down to how wide a dollar-income range needs to be maintained between changes in stop-loss limits for different cohorts of Medicare seniors. Those cost-sharing brackets certainly should be narrower than those used for the federal income tax's rate brackets, but at least wider than every ten-thousand dollar interval in

additional reported income. Congress has a good deal of experience in making similar judgments for the phase-out of income-related tax subsidies or phase-in of higher income-related taxes.

²⁶ For example, certain preventive health benefits that pass an evidence-based test for cost-saving or health-enhancing effectiveness could be exempted from the new Medicare FFS cost sharing provisions, somewhat similar to how they already are treated in HSA-qualified plans in the private insurance market today.

²⁷ See, for example, Tom Miller, “Rethinking the ‘Other’ Payroll Tax,” Real Clear Politics, January 11, 2012.

²⁸ For example, about half of all Medicare beneficiaries had annual incomes (as individuals, not households) below \$22,500 in 2012, and one-quarter of them had incomes below \$14,000. Kaiser Family Foundation, “Income-Relating Medicare Part B and Part D Premiums under Current Law and Recent Proposals: What Are the Implications for Beneficiaries?” February 2012. About 35 percent of Americans age 65 and older had incomes below 200 percent of the federal poverty level.

²⁹ See, for example, Stephen Zuckerman, Baoping Shang, and Timothy Waldmann, “Policy Options to Improve the Performance of Low-Income Subsidy Programs for Medicare Beneficiaries,” Urban Institute, January 2012.

³⁰ See, for example, note 7.

³¹ See note 7; Thomas Miller, *When Obamacare Fails: The Playbook for Market-Based Reform* (Washington, DC: American Enterprise Institute, December 2012), 20.

³² Mondale’s media director, Roy Spence, infamously praised his boss because he “dares to be cautious.” Richard Cohen, “Jackson Shows Mondale’s Caution,” *Boca Raton News*, January 6, 1984,

Mr. PITTS. The chair thanks the gentleman, and we will now begin questioning. I will recognize myself for 5 minutes for that purpose.

The first series of questions are yes or no, and I will ask all of you these questions. So Dr. Baicker, I will start with you. Is it fair to say that you all agree the traditional Medicare fee-for-service benefit design may be outdated and overly complex for beneficiaries? Yes or no.

Ms. BAICKER. I agree.

Mr. PITTS. Dr. Neuman?

Ms. NEUMAN. Yes.

Mr. PITTS. Mr. Miller?

Mr. MILLER. Yes.

Mr. PITTS. All right. Second question. Is it also fair to say that the program is need of reform to ensure catastrophic protection for beneficiaries, increased incentives for beneficiaries to seek value-based providers and services and streamline benefits to reflect a modernized benefit structure? Yes or no.

Ms. BAICKER. Yes.

Mr. PITTS. Dr. Neuman?

Ms. NEUMAN. Yes, depending on how it is done.

Mr. PITTS. Mr. Miller?

Mr. MILLER. Yes, in general.

Mr. PITTS. All right. Is it also fair to say that reforms on such a topic have been discussed for decades by policy experts from both sides of the aisle and political spectrum? Yes or no.

Ms. BAICKER. Yes.

Mr. PITTS. Dr. Neuman?

Ms. NEUMAN. Yes.

Mr. MILLER. We have problems with political markets clearing on them. Yes.

Mr. PITTS. All right. Finally, is it also fair to say that given a Medicare solvency crisis, approaches gradually but inevitably pressure to restructure the program's traditional benefit design will only increase? Yes or no.

Ms. BAICKER. Yes.

Mr. PITTS. Dr. Neuman?

Ms. NEUMAN. Yes.

Mr. PITTS. Mr. Miller?

Mr. MILLER. Yes. As the pressures increase, we have to think about how we want to respond to them.

Mr. PITTS. All right. Dr. Baicker, given that today approximately 70 percent of Medicare beneficiaries are enrolled in the traditional fee-for-service benefit with the remaining beneficiaries finding greater value in the Medicare Advantage program, wouldn't a modernization of the traditional benefit design ultimately help the majority of current Medicare beneficiaries navigate a very complex cost-sharing structure and effectively avoid the implications of catastrophic illness cost?

Ms. BAICKER. Yes. I think modernizing the design would allow beneficiaries to consume the care that was right for them in the right setting and from the right provider, and that added flexibility could drive towards higher-value care for all beneficiaries. I think they should have choices about these things.

Mr. PITTS. Mr. Miller, do you want to comment?

Mr. MILLER. Cleaner, clearer signals are important. We may in trying to adjust for everything make the system even more complex.

Mr. PITTS. All right. Dr. Baicker, you note in your testimony that cost sharing should be modeled on a value-based framework whereby cost sharing is lowest for services that are most effective at improving health care outcomes. Could you please elaborate? Explain from your experience in looking at private-market options where cost sharing has worked most effectively.

Ms. BAICKER. Let me give an example from the care of diabetic enrollees who have really high risk of downstream adverse cardiovascular events, and getting them to adhere to their medications, getting them to meet with their physician regularly can improve their health dramatically and reduce downstream costs. There are a lot of innovative ways you can try to get diabetics to be more adherent to best practices, and in the absence of innovation in different types of interventions, we see remarkably low adherence rates to lifesaving treatments that patients just have trouble on their own enforcing, so innovative cost structures where maybe patients even get subsidized to take their medications or where they don't meet with a physician all the time, they sometimes meet with a community care person who coordinates across different patients to provide support for them to take their medications. I think we have seen that the crude tools are insufficient, even for a population where there is effective care available and the downstream consequences are potentially catastrophic for their health, and we see that kind of innovation in the private sector and it is very hard for the current Medicare fee-for-service structure to mimic that kind of innovation.

Mr. PITTS. Dr. Neuman, do you want to comment on that question?

Ms. NEUMAN. I would agree with everything. I think the challenge is, who determines what is high value and what is low value, and that is really a major issue in terms of figuring out who would make these determinations. An easy example to think about in terms of value might be generic versus brand for equivalent products, but when you get to the more complex questions involving medical care, these decisions are a little bit trickier to resolve. So I think that is a particularly good example. I know that in the MedPAC recommendation, they talked about delegating this authority, I believe to the Secretary, because they were not prepared to specify when they made their recommendation what exactly is high value and what is not.

Mr. PITTS. Mr. Miller?

Mr. MILLER. This is a perpetual struggle in trying to get the benefits of what we point to in private-sector private insurance innovation and trying to do that through a comprehensive public program which has a lot of difficulties in making those types of fine-tuned adjustments and being accountable for it. We have got a one-time shot to get the basic shell of a structure for Medicare benefits better, but I think we can't legislate every single particular in that regard. I would suggest that although most of these proposals say well, we will just give the Secretary some discretion, it will all

work out, there will be some rulemaking, you need to have some evidentiary boundaries as to exactly how far that is going to go. Most of the examples of value-based insurance design tend to be one-sided. We know how to add benefits that make everybody happy and feel better. We have a lot more problems in taking them away. So you could impose somewhat of a budget neutrality constraint saying for everything you need to put on, if it is going to pay off, something else has to not pay off as well, and that is one way to get it a little more even-handed rather than a one-sided approach.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member, Mr. Pallone, 5 minutes for questioning.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to ask Dr. Neuman, many of the proposals for redesigning Medicare's benefit package attempt to balance program simplification through combined deductibles and more predictable out-of-pocket expenses with efforts to improve the program value and efficiency. Many of us would agree that there is a need to simplify the structure of Medicare benefits in ways that make it more understandable and user friendly for beneficiaries and provide them with better protections by providing out-of-pocket spending caps like private insurance plans.

Your analysis clearly shows that while a small number of beneficiaries would benefit from their restructured design, a much larger number would see increased out-of-pocket expenses. Can you talk about how with any of these plans there will be inevitably winners and losers?

Ms. NEUMAN. Well, there are 50 million people on Medicare, and everybody has a different set of health care experiences and health care needs and supplemental insurance, which varies across people, and when you change the benefit design, depending on what services people use in a given year, their out-of-pocket costs are going to differ than what they would have been under current law. So in sort of the prototype policy that we looked at, the high out-of-pocket expense of course protects a small share of people. The high out-of-pocket limit protects a very small share of the Medicare population with high spending. That costs. When you add a benefit to Medicare, that increases Medicare spending, and part of the new costs are offset by the higher deductible that so many more people on Medicare will pay because 80 percent of people don't go to the hospital, so 80 percent of people don't incur an inpatient deductible. So for the majority of people who don't go to the hospital, they would pay a higher deductible and so they would see their deductibles increase if this were to be imposed, for example, this year.

Mr. PALLONE. OK. Now, how can we design a plan that is mindful of the financial insecurity of the large number of Medicare beneficiaries and builds in adequate protections?

Ms. NEUMAN. Well, I think it is tricky if the goal is to produce savings, so in an environment where the overall objective is to produce Medicare savings, it could be quite challenging to build in protections and to lower cost-sharing risk for people with modest incomes. To protect people with modest incomes, one might think about, for example, the Bipartisan Policy Center's initiative which

federalizes cost-sharing assistance for people with incomes between 100 and 150 percent of poverty. This is building on the Part D model for low-income subsidies, but adding protections also adds to cost, so to do this, one would need to find a way to offset those costs in some fashion.

Mr. PALLONE. OK. Dr. Baicker, I know your research has looked at a lot at value-based insurance design, and one of the points you make is that cost sharing as it currently is used in the insurance industry is a blunt tool. It reduces health care spending but in a way that doesn't differentiate between high- and low-value care. It also doesn't take into account the diversity of the beneficiary population who based on their financial and health status are likely to respond differently. So unfortunately, the notion of creating incentives for beneficiaries to make better decisions is often looked at only through the narrow lens of increased cost sharing. Can you talk about ways other than increased cost sharing that benefits can be structured to encourage use of appropriate high-value services and discourage the use of unnecessary services and how important is it to ensure there are not barriers to high-value care?

Ms. BAICKER. I think you raise a really important point, that cost sharing on the patient side has some potential for harms, especially if it is implemented for all patients in the same way, and on the patient side, the ideal cost sharing might depend not just on the service or the medication or the setting but also on the particular patient. So a cholesterol-lowering drug for a diabetic patient is higher value than that cholesterol-lowering drug for a different patient, and it is very hard to write down a set of rules for specific procedures or specific medications and call them high value and others not when it really varies patient to patient. So it would have to be a much more flexible design on the patient side, which we have seen some experimentation with in the private sector but we are nowhere near achieving the possibilities.

On the provider side, I think one could also approach promoting higher-value care by making payments look across silos, and that means not paying more for care in one setting than another setting when the patient might be better off individually in the setting that is less well reimbursed. The reimbursement should really be neutral about where the patient gets the care, so the patient could choose based on what is best for that particular set of circumstances. There could also be payments on the provider side that bundle care across silos and over time. Those bundles have to be big to incorporate, from the physician's office to the hospital to the post-acute care where there is a huge amount of variation in spending in post-acute care, and somebody has to be responsible for that in the provider system so that patients get high-value care after a hospitalization that not only improves their health but keeps them out of the hospital again. So I think we have to approach it both from the patient side but, as you note, from outside the patient side from the provider side as well.

Mr. PALLONE. All right. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman. It is great to have you here—an issue that has befuddled the national government, prob-

ably since the inception of Medicare in 1965. Those of us that have been around for a long time, I can't think of a time when I haven't talked about the structural deficiency and our promise to pay future generations based upon the formula that we have today. And so thanks for this.

I am kind of going to go to—my question is going to be first, if people can shop around for homeowner's insurance and automobile insurance, do you think it is too much to ask for individuals to shop around for health insurance? Why don't we go left to right?

Ms. BAICKER. I think individuals should have choices among health insurance plans and I think that that would foster innovation in insurance design as well as competition on prices but insurers should be experimenting with the best way to manage diabetic enrollees, for example, and then they should be able to attract more of them by providing higher-value care.

Mr. SHIMKUS. And Dr. Neuman?

Ms. NEUMAN. I think people on Medicare should have choices, and people on Medicare, for example, do have the ability to shop within the Medicare Advantage program today. I think as people get older and have more impairments and cognitive impairments, then the shopping process gets more difficult because it is—I think we have all experienced looking at health insurance and it is a fairly complex enterprise.

Mr. SHIMKUS. It is. I guess the other issue too is if—and I can really understand the debate on seniors at a certain age but it is still seniors at a certain age that are still buying automobile insurance and they are still paying home insurance, and there is a training process too. You can't expect seniors today, a lot of seniors today who are on fee-for-service to automatically move into a competitive-market model and shop around. I think that is really in essence way too much to ask. But you all get the drift I am going. Mr. Miller?

Mr. MILLER. We can certainly improve the shopping process for insurance but we sometimes overinvest in it too much. Kate was talking before about getting into broader bundles. What we really want to have is measures of outcomes for all of the players who are providing our care, and that goes beyond just the insurer you select. So we need to think about how seniors can shop more effectively for the team of care they are going to receive or the various folks they go to first further on down the stream, particularly in Medicare fee-for-service where you are not buying as much of an orchestrated, integrated product. So as much as we want to enhance the shopping experience for that front-end idea of what are my benefits, what are my cost sharing, we need to know what actually what is the value of that total experience.

Mr. SHIMKUS. Even in the much maligned or supported ObamaCare or Affordable Care Act, the premise is getting people into markets, State exchanges, where they can shop around, and so this really is a segue to that whole issue. If you can then move the public at large either by their employer or the individual citizen, in essence forcing them to shop around in an individual exchange, why isn't the segue then into future generations move these people then into a market-based system of health insurance providers for Medicare and Medicaid? And that might even also ad-

dress the payment disparities that you see from these two programs, which the majority would much rather pay the Medicare rate than they are going to receive on a Medicaid reimbursement, which really distorts this whole funding scheme. Does anyone disagree with that, or anything to add?

Ms. BAICKER. I think making it easy for people is key. Competition doesn't work if people aren't able to evaluate the options in front of them and aren't able to move, and that is about making information transparent, and it is also about sort of smoothing pathways. We know that it is hard for people when they have so many different choices and the information is varied to make wise decisions.

Mr. SHIMKUS. Let me just jump in because my time is short, but Dr. Neuman, you kind of mentioned it, and you were kind of leading up, I was kind of building momentum here for this thing, does Medicare Advantage strike this balance to some extent of allowing people choices and systems and a way to shop around that could be in essence kind of rolled up writ large, I think?

Ms. NEUMAN. You know, it could. People have the choice of traditional Medicare and Medicaid Advantage plans, and then if they choose Medicare Advantage plans, they can choose among them. We don't really know very much actually about how people are choosing plans and whether they are choosing the best plans for them. We know in the Part D marketplace that people are actually not making choices in terms of which plan would reduce their cost the most. So we still are pretty early on in this experiment in terms of understanding how seniors behave in the marketplace.

Mr. SHIMKUS. But Part D, I don't know the recent approval ratings or the like but it is still well received.

Ms. NEUMAN. Oh, yes.

Mr. SHIMKUS. And approval ratings are higher than any health care thing we passed ever in this chamber. So it is a very successful model.

I yield back my time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the distinguished ranking member of the full committee, Mr. Dingell, for 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy, and I thank you for holding this hearing today. It is very important.

As most people know, my dad was the originator of Medicare, and I was proud to cosponsor the legislation and to provide over the House of Representatives during its passage. The program has endured as one of the most significant pieces of legislation in our Nation's history and is it of enormous importance to our senior citizens and to a lot of other people. I recognize that it is time for review on a continuing basis of this great program, and I believe that we can do so without limiting or decreasing benefits that are available to our seniors today as we look to see to it that it is conducted in the most efficient way from the standpoint of costs and other things.

Now, the testimony focuses today on a number of proposals on how to reform Medicare. I want to focus my questions on the impact these programs and reforms would have on seniors. Dr. Neuman, these questions are directed to you as spokesman for the

Kaiser Health Foundation, and I want to thank you and the other members of the panel for being here. Your assistance is much appreciated.

Doctor, is it correct that nearly one in four of Medicare beneficiaries are only in fair or poor health?

Ms. NEUMAN. Yes, sir.

Mr. DINGELL. Doctor, is it also correct that 40 percent of Medicare beneficiaries live with three or more chronic conditions?

Ms. NEUMAN. Yes.

Mr. DINGELL. Doctor, do more than half of Medicare beneficiaries live on incomes of less than \$22,500 a year?

Ms. NEUMAN. Yes.

Mr. DINGELL. Dr. Neuman, does Medicare have a limit on out-of-pocket expenses for beneficiaries?

Ms. NEUMAN. No.

Mr. DINGELL. Dr. Neuman, is it correct that Medicare beneficiaries with incomes below \$20,000 per year spent something like 20 percent of their income on health-related expenses?

Ms. NEUMAN. Yes.

Mr. DINGELL. Now, Doctor, thank you. It is clear that we have many beneficiaries for Medicare who have serious health needs and very limited resources to pay for their care. Placing cost-sharing requirements on this population is going to have to be done very carefully or it will have an appalling negative impact on their health and financial security.

Now, the Kaiser Family Foundation recently commissioned a study, which has been discussed this morning, on the impact of three reforms that have been proposed by many different groups: a unified copayment for Parts A and B, a 20 percent coinsurance for Medicare services, and a \$5,000 annual limit on out-of-pocket spending. Dr. Neuman, did this study find that 71 percent of the beneficiaries would see an increase in out-of-pocket costs to them if this plan was implemented this year?

Ms. NEUMAN. Yes.

Mr. DINGELL. Now, Doctor, did this study also find that aggregate spending among Medicare beneficiaries would increase over \$2 billion?

Ms. NEUMAN. Yes, sir.

Mr. DINGELL. And Doctor, I hope you understand, I am doing this so we can get an awful lot into the record as opposed to putting you in any kind of a difficult place.

Doctor, do you believe that these proposed reforms would also lead to increased costs for beneficiaries if not structured properly?

Ms. NEUMAN. Yes, I think there is a risk that that could happen.

Mr. DINGELL. And I believe you are suggesting that if we do this, it should be done with all the facts and with a great deal of care.

Ms. NEUMAN. That is correct.

Mr. DINGELL. Now, I think we need to take a good, hard look at the ways that Medicare can be reformed so that the program continues to provide security for our future generations. However, we must ensure that such reforms are not simply shifting costs from the federal government to senior citizens who are incapable of properly meeting those demands. Medicare is a promise to our senior citizens, and we need to keep our word to them. I am confident

that we can improve the program while protecting access to care if we work carefully together in a bipartisan manner.

Mr. Chairman, I want to thank you for recognizing me. I want to commend and thank our panel, especially you, Dr. Neuman, and I hope that as we proceed forward, we will do so with exquisite care. We have a program of vital importance to our senior citizens, one which must be protected and one which with unwise tinkering can cause no end of problems. I also note that if properly done, it is a program which could continue to persist in its service of our people for a long time into the future and that the corrections are not disastrous if properly done. Thank you, Mr. Chairman. I yield back 1 second.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questions.

Mr. CASSIDY. Hello. Thank you all. I enjoyed your testimony and your written testimony. Mr. Miller, I think I may end up quoting some of yours but I won't quote it here.

Mr. MILLER. It is there for your use.

Mr. CASSIDY. Dr. Baicker, I think it may have been your testimony where you hint at, indeed, it may not only be expensive to have overutilization of services but also harmful to the patient's health. I see both of you nodding your head. I agree with that totally. So let us be clear: When we speak about using services more widely, it is not only monetary but most importantly it is about making sure that patients' health is not harmed. Yes?

Ms. BAICKER. I agree that not harming health is clearly first and foremost, and then there is also care that is of potentially zero benefit or very small benefit that is really expensive.

Mr. CASSIDY. OK. Now, one thing that you read about is the activated patient, the activated patient whose expenses are 8 to 21 percent lower than the person—and I gather there may be even some empiric evidence that the activated patient is a healthier patient. Just for those listening who may not know, an activated patient fully participates in their care both physically and financially.

Now, have any of you all—and try to keep your answers brief, please—do any of you have specific suggestions or the things that you suggested do you feel as if they would create the so-called activated patient, the one participating both in their health decisions as well as their financial decisions. For example, Mr. Miller, you speak of value-based purchasing as do maybe all three of you. I don't really think of that as creating an activated patient. That is actually just saying we are going to pay for this and not pay for that.

Mr. MILLER. The decisions are made before the patient is asked about it, and we are steering them in that particular direction. Now, we can do that in some areas. Certainly the best evidence tends to be in the prescription drug area. That is largely accommodated through Part D already in Medicare. So I think we can move that mostly off the table.

Mr. CASSIDY. So by incentivizing patients to go to generics and allowing them to save money, you create an activated patient who is both looking at the cost but also doing so improving—

Mr. MILLER. Looking at the cost opens the door to thinking about the value. Cost is only the opening consideration, but if you haven't gotten someone's attention with the cost, they may not think about how that balances out against the qualitative tradeoffs.

Mr. CASSIDY. Now, Mr. Miller, I like your kind of testimony, if you went to a higher coinsurance but you still had the same limit on out-of-pocket, you may achieve both, maybe more upfront costs but—

Mr. MILLER. You are trying to expose more patients across a wider range of decisions to thinking about the care they receive.

Mr. CASSIDY. Now, let me ask you this, and this is something I haven't completely worked through, so if I totally fumble, please forgive me. As some hospitals are purchasing physicians' practices, typically procedurally based, and they are beginning to bill under Medicare Part A as opposed to Part B, effectively we are having what you are describing in which the deductible for that Part A service is often greater than it would be for the equivalent Part B. We are seeing a downward trend in Medicare spending. I tried to learn if that is attributable to this phenomenon. That is more difficult than it seems like it should be. I have not yet been able to determine that. But it seems to me that we may be seeing examples of what you are describing, bringing it into Part A, increasing the upfront deductible and coinsurance costs, and yet there has been no decrease in health quality and there has been a decrease in spending. Any thoughts on that?

Mr. MILLER. Well, I have not looked at that data. I mean, we have got a different type of thing going on where hospital outpatients, because it is reimbursed more generously than other outpatient—

Mr. CASSIDY. But that costs the patient more.

Mr. MILLER. Which is the problem of all these type of siloed payments. Other private parties will find ways to maneuver around them.

Mr. CASSIDY. Oh, I accept that as a different thing, but just my general point, that we have effectively increased the amount that is out of pocket for patients and we have actually seen a decrease in spending in the Medicare program, in the Part B program.

Mr. MILLER. Right.

Mr. CASSIDY. Any thoughts on that, Dr. Baicker or Dr. Neuman?

Ms. BAICKER. I think you hit on a key point that innovative insurance companies can drive patients to be more engaged in their own care, and that innovation could come in the form of cost sharing or it could come in other ways that insurers think of to get the patients engaged and having them have that flexibility would open a wider set of—

Mr. CASSIDY. What are some other examples of how they could be engaged besides cost sharing? Because clearly we need patient engagement.

Ms. BAICKER. I think there are examples of getting patients to interact with a wider set of patients who have conditions like them, of getting text messages to remind them of things, of getting—

Mr. CASSIDY. I have heard about that. Has that actually been shown in some sort of peer-reviewed double-blind way to actually work?

Ms. BAICKER. I think text messages do increase adherence to medications, that part of not taking your meds is not about the copay, because you already have the drugs, but taking them regularly, it is a skill, it is a habit, and there has to be skill building that if you don't have the right incentives, insurers don't engage and providers don't engage in patient——

Mr. CASSIDY. So if you, though, that is not the insurance product per se but rather the administration or patient care aspect of it, correct?

Ms. BAICKER. But if the insurers and the providers have the right incentives, then they can innovate in that dimension that benefits patients by getting them more engaged, and you need a system that incentivizes upstream for that to happen downstream.

Mr. CASSIDY. Thank you all. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Well, thank you, Mr. Chairman, and thank you all for your expert advice provided to the committee.

I want to start off by saying thank goodness for Medicare when you look back over the past decades what security that has brought to our families all across America, our parents and grandparents. We don't have to worry about our older neighbors falling into poverty because of their health issues as they get older.

And now with the Affordable Care Act, Medicare is even stronger. We have already adopted very important reforms moving benefit. The benefits for Medicare beneficiaries are better. The life of the trust fund has been extended. It is not great, though, and I worry because I see this huge population of the baby boomers now coming into Medicare as they turn 65, and I think this is the right time to look at reforms.

One recent proposal was called the Medicare Essential proposal by Karen Davis and others in the Commonwealth Fund. They propose to combine Parts A, B, and D with a single deductible, copayments, and a ceiling on out-of-pocket costs. In addition, it would build incentives for beneficiaries to choose the high-value care we have talked about this morning including having them join those primary care practices that quality as patient-centered medical homes and using providers participating in alternative payments like ACOs. I have seen some of these in Florida where they are very intensive. The nurses are on the line constantly with their patients talking about smoking cessation, taking their medications, but it is still very difficult. And the inherent part of that proposal is the assurance of equitable access for low-income beneficiaries.

Dr. Neuman, what is your view of that proposal? Do you have any criticisms or do you want to highlight the good parts of it?

Ms. NEUMAN. Well, I think it is a proposal—you are looking at a lot of proposals that are trying to achieve similar goals. This proposal is certainly worth looking at, and particularly the features that would provide the catastrophic protection and to encourage people on Medicare to move toward systems where there are incentives to improve the delivery of care, and I think there is a lot of interest in giving beneficiaries access to the kinds of care coordinators, nurse practitioners, the kind of services that you were talking about that you have seen, and that would be encouraged under this

proposal. It has a relatively low limit on out-of-pocket spending. It has a fairly low deductible. So I think it recognizes the needs of people with modest incomes, so I would encourage you to take a look at that.

Ms. CASTOR. OK. Doctor, do you want to comment on that?

Ms. NEUMAN. Yes, I do think that there are a lot of common threads in these proposals where there is a consensus emerging that the protections that Medicare affords are vital and have to be preserved but that moving patients towards programs that foster whole health, that look across silos are really engaged with patients to activate them and to ensure that they are consuming the care is actually going to produce help for them with the highest value. There are a lot of common threads. Optimistic? I don't know if that is reasonable that we do it that way.

Ms. CASTOR. Mr. Miller?

Mr. MILLER. Well, I looked at the Part E proposal, which is somewhat of an update of an older one a couple of months ago. I appreciate the creative use of the Medicare alphabet but I think it is really aiming for Medicare Part U, universal, which trying to squeeze out private competition, if you look at the actual underpinnings of it, and there are a number of—

Ms. CASTOR. Well, that raises another point, because I think the Medigap policies, the supplementals, I get your point about are they encouraging overutilization, and they seem to be ripe for reform and cost savings too. When you look at traditional Medicare, the administrative costs are only 2 percent. You look at those Medigap policies, and administrative costs are 20 percent. That is awfully high.

Dr. Neuman, where should we be headed in reform of those supplemental policies?

Ms. NEUMAN. Well, the loss ratio requirements haven't been looked at for some time, so that might be something you might want to look at with Medigap policies. I think the issue with Medigap is, it may drive up utilization and spending and Medicare services but people really rely on Medigap for the security that it provides. People seem to want protection. They don't seem to want to have an unpredictable, unaffordable medical expense occur throughout the year. There are kind of two sets of proposals out there on supplemental insurance. One would prohibit first-dollar coverage for Medigap. The other is a surcharge approach or a tax approach which would tax both Medigap and employer-sponsored plans, and they would have very different effects, depending on how they are implemented.

Ms. CASTOR. Thank you very much. I have run out of time.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from Kentucky, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. A perfect trend. My friend from Florida led right into my questions. I was going to talk about Medigap.

A lot of times we talk about transparency in pricing and you can't find the pricing in health care, and if you go to the Houchins IGA grocery store in Bowling Green, Kentucky, there is a price on everything, because if they didn't have a price on anything, nobody would buy anything because it is out of their pocket. They have got

a sign tall enough you can see what their gallon of gas costs going down I-65 at 70 miles an hour. So that is just a problem. But I will tell you this: if I paid \$100 a month to Houchins IGA and they allowed me to come in and buy anything that I wanted to because I paid \$100 a month, not only would prices go away, I probably wouldn't make too intelligent of at least value based. I would buy the T-bone steak every time I went in.

And so there was a 2009 MedPAC study—I think we just started getting into it—about beneficiaries with first-dollar coverage and they use the system about a third, or they have a third higher medical costs than those with no supplemental, and the first-dollar coverage regardless of type of plan results in higher Medicare spending. And in the June study, MedPAC made some recommendations to address this. I think we talked about one is a copay, a fixed-dollar copay, and the excise tax that you talked about. I have some concerns with it. One is that if, say I pay \$100 a month for it and all of a sudden they say you are going to have to pay a tax so you have to pay \$110, well, that \$10 will go into the trust fund, I get it, to help offset my cost. That doesn't change my behavior at all. So that just doesn't seem to—other than putting money in the system, it doesn't seem to have any change in me using a third more.

Ms. NEUMAN. I think it might have an effect. The effect might be different for people with lower incomes. So for people who can afford the extra \$10 in your example, they pay the \$10 and they keep their coverage and life goes on and they use services as they did. For people who can't afford the \$10, they would probably give up their supplemental coverage or they may give up their supplemental coverage and then they would face the true costs of whatever services they used and—

Mr. GUTHRIE. But that would have a negative impact on the poor and the excise tax would have a negative impact on the poor recipient. So it could price people out of the market is what you are saying?

Ms. NEUMAN. That is right.

Mr. GUTHRIE. But I guess I would like to talk just—I have got 2½ minutes—of this whole first-dollar coverage and what you think should change that. I think Mr. Miller is about to start.

Mr. MILLER. I was just going to add, in the Medigap area we already have plenty of evidence that people buy plans that cost more than \$1 for a \$1 in benefits. So we can go through the, you know, approach of taxing them a little bit more and making it even less of a good deal. I suspect we will still have some people buying it. But the 2009 study was very well crafted, because there has been a lot of older evidence on the extra costs that are thrown off by supplemental coverage. I think it dealt with some of the criticism of the earlier work and made it quite clear that more so for individual Medigap-purchased insurance, less so for employer-sponsored insurance, but all of them have a higher cost impact on Medicare, and that is not covered by the Medigap premium or the employer costs; it is passed onto every other Medicare beneficiary.

Mr. GUTHRIE. But it continues to add into that “I don't have to price my health care because it is being covered from first-dollar coverage.” Dr. Baicker?

Ms. BAICKER. And in general, when you tax things, people consume less of them, and the goal I think would be to reform the basic Medicare benefit so that people have the vital financial protections and didn't need the Medigap policies as much, and then pricing the Medigap policies would take into account the extra cost they impose on Medicare and other Medicare beneficiaries and would hopefully induce people to move towards plans that didn't have so much first-dollar coverage because they were getting their out-of-pocket protections from the main Medicare program. They would then scale back the consumption of care that is of less value and everybody's care would be a little more affordable. There are a lot of steps in that chain, and there is a lot of uncertainty about how big each of those steps would be but we know that Medigap policies today are priced much lower than their true cost and so we are subsidizing the kind of care that produces very little health, and that doesn't seem like a great way to continue.

Mr. GUTHRIE. Any further discussion? Dr. Neuman, any other points?

Ms. NEUMAN. Well, we are subsidizing—some of what we are subsidizing probably produces good health but some of it may not, so there is a mix there.

Mr. GUTHRIE. But there is a desire in this. We have to recognize that people want to insure themselves against “I just don't want to have to face this. I would rather pay a little bit each month and not have to face it.”

Ms. NEUMAN. Many people on Medicare are living on fixed incomes so they don't like the idea.

Mr. GUTHRIE. Exactly. So it is a good benefit.

Ms. NEUMAN. And I think the issue here is in a benefit redesign, if the deductible is relatively high and the out-of-pocket limit is relatively high because of budget constraints, then it may not dampen the demand for supplemental coverage if people still will feel exposed to a high deductible and they can't afford to get to that limit.

Mr. GUTHRIE. I think I just ran out of time. I appreciate it. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from Virgin Islands, Dr. Christensen, for 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. Welcome to the panel this morning.

Dr. Neuman, I really appreciate your testimony, especially your focus on economic circumstances and health status of Medicare beneficiaries and they need to be mindful of both the intended and unintended consequences of benefit design.

Broad cost-sharing requirements have a significant impact, as we have said, on low-income seniors. I worry that even with an attempt to build in low-income subsidies, this could still create barriers to necessary health care for vulnerable seniors and worsen health disparities that already exist. Could you comment on that further?

Ms. NEUMAN. You raise a good point. There are enormous disparities in income and assets of seniors by race and ethnicity. So people of color would be negatively affected by an increase in cost

sharing unless there were adequate protections. That is a real issue.

Mrs. CHRISTENSEN. And we have heard a lot this morning of course because the focus is on Medicare today, but Medicaid is also an important program for millions of seniors and benefit design could affect that. Could you talk about the role Medicaid plays for these low-income individuals and why it is so important?

Ms. NEUMAN. Yes, Medicaid plays an enormous role in providing financial security for people with very low incomes and very modest assets. So today Medicaid fills in the gaps, helps with cost sharing, helps with premiums, provides other benefits, but not all low-income qualify and are covered by Medicaid. So for those who are just above the Medicaid eligibility level, they are responsible for their full cost-sharing obligations and premiums and uncovered services are everyone else is and may or may not be able to afford supplemental coverage.

Mrs. CHRISTENSEN. Right. I will just take off from that. Some people have proposed limiting the amount the federal government pays for beneficiaries, either through a cap or per-person payments or cap on total federal spending. How might such a proposal affect coverage for access to care for these vulnerable populations?

Ms. NEUMAN. I think it would shift the risk from the federal government or State governments to the Medicare population and the poorest on Medicare.

Mrs. CHRISTENSEN. I am just curious. As a physician who took care of Medicare patients, a lot of comments have been made about the increased cost when there is not significant cost sharing. In my experience, Medicare did not pay for unnecessary care, so is it a guarantee that just having no cost sharing increases the cost? Because it might increase visits but if Medicare doesn't pay for visits that are unnecessary, tests that are unnecessary—and anyone can respond. I am just curious, because I have had things denied reimbursement.

Ms. BAICKER. So I think you are highlighting that the black-and-white nature, necessary versus unnecessary, is much messier in the real world. There is a continuum of value that care produces from urgent lifesaving care to care that I do think is unnecessary or even potentially harmful. If you look at the example of testing for prostate cancer in older men, Medicare pays for that, and there is an age beyond which the test actually can do more harm than good because it is detecting cancers that would not actually kill the person and it subjects the patient to downstream procedures and costs that may actually do them harm, and Medicare does pay for that. At the same time, it makes mistakes in not paying for stuff that is valuable. So I think there are both types of mistakes in the current program: paying for stuff it shouldn't and not paying for stuff it should.

Mrs. CHRISTENSEN. Well, I also think on that prostate issue that we probably need some more research done and information, but providers can make judgments even at an older age with a person that has a positive or a high PSA.

I am going to yield back the balance of my time, Mr. Chairman.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much, and I thank you for your testimony.

The question is for Mr. Miller. First question, in your testimony you talk about various ideas of structuring benefits with different cost shares and deductibles. Is it worthwhile to have multiple Medicare plans in the marketplace? First question. We could establish an actuarial value and allow various plans of different premiums, deductibles and cost shares. This would allow seniors to choose a plan that fits their lifestyle and health status rather than a one-size-fits-all plan.

Mr. MILLER. It is correct that there is more than one way to configure insurance benefits, and certainly seniors should look forward to that. I think what you are hinting at is a better structured version of the current competition we have between fee-for-service Medicare and Medicare Advantage plans and the premium support model, which could provide that type of more vibrant competition. You have to have a starting point, though. How is the basic benefit defined legally from which then plans can vary in terms of how they meet an actuarial equivalent of that or charge a supplemental premium for people who want more coverage than what that basic one is how the bids are determined. There is a harder question as to whether or not we can allow the Medicare fee-for-service program to offer more than one version. People are a little resistant to that, but if that enhanced Medicare fee-for-service with other benefits is not subsidized, where it is actually charging an extra premium that people have to pay the cost of it, then that would be the type of level playing field competition that we always talk about in theory but never deliver in practice.

Mr. BILIRAKIS. Thank you. Next question for all. I know we have touched on a lot of these issues, but I want to give you an opportunity to elaborate a little bit. This one has to do with transparency.

One of the great challenges of health care is the issue of price transparency. Health care is perhaps one of the biggest sectors of our economy where no one really knows the cost of service. I go to the doctor, I pay a copay, I know what the cost of that visit is before I go. I go to the doctor, I pay a coinsurance, I don't know what the visit will cost me until after the visit. When designing a new benefit structure, how can we increase the level of transparency in the system so beneficiaries can know what their costs will be before they even visit the doctor? And that is a question for the entire panel.

Ms. BAICKER. So this is something beneficiaries complain about rightfully a lot, that they have no idea how much a service costs, and physicians aren't really in the business of giving them that information either, and so one model is to go to copayments where you know \$10, \$20. It is known ahead of time. Another model is to make sure that the prices are easily knowable to the patients beforehand so they can make informed decisions and so their providers can help them too. If the providers don't know how much something costs, how can they make recommendations that are in their patient's best interests?

Mr. BILIRAKIS. How do you suggest we do that?

Ms. BAICKER. Well, there could be a requirement that prices are transparent, and that is going to depend on what insurance product the patient has and what has been negotiated between the insurer and the provider. There could be a move towards copayments instead of coinsurance. Either could achieve similar ends in terms of transparency but would have different effects, I think, on the negotiations between insurers and providers, not in the case of fee-for-service Medicare, of course.

Mr. BILIRAKIS. OK. Dr. Neuman?

Ms. NEUMAN. Well, I would just say it is less of an issue with fee-for-service Medicare than it is in the commercial market for the rest of us who are out there wondering what the price of various services are. I think copayments would be a lot easier for people in Medicare to understand. That is what a lot of the Medicare Advantage plans are doing now. And I think it would just be easier to anticipate well, if I go to the emergency room versus go to my doctor, I am going to pay this much more so I better—I should try to wait and see my doctor.

Mr. MILLER. If you want beneficiaries to know the real costs of the care, copayments are somewhat, you know, sometimes well, sometimes arbitrarily assigned and they tend to converge in certain clusters. If you go to a coinsurance approach, if you know the coinsurance rate and it tends to be uniform, you automatically know what the full cost of the covered service was. It just a simple matter of multiplication. So you both see what you are paying and you know what the all-in cost was that other people are picking up.

Mr. BILIRAKIS. Very good. Mr. Miller, traditional Medicare fee-for-service operates in two different silos, Part A, of course, and Part B, without either part talking to each other. Medicare Advantage provides a comprehensive benefit with better coordination between a hospital and the outpatient settings. Do we have data evaluating Medicare Advantage against traditional fee-for-service? Does Medicare Advantage provide lower costs and better outcomes compared to the traditional fee-for-service?

Mr. MILLER. We have some studies which if you look at certain areas will say they are more effective in what they do. I don't think there is a comprehensive evaluation which can do an apples-to-apples across-the-board evaluation of that because the programs operate so differently. In addition, although we have changed some of the rules for the way the bids are set up and how they are reimbursed, we have not had them operating on the same level playing field entirely. So for a period of time we paid more to the Medicare Advantage plans in order to bring in more service and more enrollees. Now that is being pulled back. We are not exactly at a total equivalence to make an all-in comparison.

Mr. BILIRAKIS. What lessons have we learned from Medicare Advantage, the entire panel, if we redesign traditional Medicare?

Ms. BAICKER. So I think Medicare Advantage has evidence of better coordinated care, although not uniformly lower costs. I do think there is the potential that when Medicare Advantage promotes best practices and higher-value care, that can have system-level consequences because the same hospitals and the same providers treat MA patients in traditional Medicare patients so if they improve their efficiency for a critical mass of patients, that can have sys-

tem-level ramifications, and we see some evidence of those spillovers.

Mr. BILIRAKIS. Dr. Neuman?

Ms. NEUMAN. In a recent review of the literature, we have found that there is sort of mixed evidence, and the evidence is pretty early, so there is some evidence of some positive outcomes and indicators from Medicare Advantage plans but not all Medicare Advantage plans are alike, and so I think it will be important to see what constitutes an effective plan and what produces positive outcomes, and I think we don't quite know yet.

Mr. BILIRAKIS. Mr. Miller, what lessons have we learned?

Mr. MILLER. We have learned that it is pretty hard to do this, particularly through political means, and I think the lesson we should take is perhaps if we can get it out of Washington into the hands of doctors and patients, we might actually begin to sort this out and find a better balance.

Mr. BILIRAKIS. Very good.

Mr. PITTS. The gentleman's time is expired.

Mr. BILIRAKIS. Thank you.

Mr. PITTS. The chair recognizes the gentleman from Maryland, Mr. Sarbanes, for 5 minutes for questions.

Mr. SARBANES. Thank you, Mr. Chairman.

I wanted to shift away—we have been talking about sort of in the context of the Medigap policies and so forth—about what you do to address over utilization of procedures and services that may not be as necessary as others on a continuum. I wanted to go to the other side of the spectrum and talk about how reimbursement methodology and the benefits structures can address underutilization of services, particularly on the preventive side, that we would like to see patients take up more, and we have seen some reforms have gotten a lot of attention in the last year or two. Annual wellness visits now are covered without a copayment, so there is no out-of-pocket expense for the patient—certain kinds of screenings, mammography screening, colonoscopy, and so forth. But I wondered if you could just—all the panelists could just speak to that end of the spectrum and some of the innovations you see that really go to this goal of empowering patients to be full partners in their care, which is really talking about how do you boost up the preventive ownership that they have, and also speak to not just the services that get provided that are preventive services, let us say, but some of the new technologies that are being made available that patients can use to better manage their own care on the prevention side and what sort of coverage and benefits do you see coming into the picture there.

Ms. BAICKER. That is a big and important topic, and I agree with you that sure, payments can influence underutilization. Some services are underutilized because they are underreimbursed but there is a whole world of other behavioral factors beyond payments that affect patient engagement and adherence and management of their diseases, and innovation in provision of those preventive services can range from—there are medicine bottles that now can radio whether the bottle has been opened or not so there can be external monitoring and promotion of adherence. You know whether the patient has actually taken the pill. There are visiting professionals,

nurses, other health care providers who can help coordinate care in the home for patients who have trouble getting out of the home or coordinate patient groups, and I think all of those mechanisms for investment in wellness have potential long-term really big positive implications, and the reason we see employers getting involved is that people often have a longer-term relationship with their employer than they do with their insurer and they spend eight-plus hours a day in the workplace, and that is a great site to promote that kind of investment.

Ms. NEUMAN. I am going to talk about prevention in a different sense for an older, frailer population. So there are delivery-system reforms being tested now, for example, the Independence at Home demonstration, where a physician and teams of professionals come into the home with the idea of engaging the patient and family members to prevent patients from needing to go to the emergency room or having to go to the hospital, and they employ technology in the home that can help the medical team and the social services support team monitor what is going on in the home in order to provide care in the most appropriate setting, which in this case is also the lowest cost setting and what patients and their families prefer. So through technology and through a tested intervention of providing team-based care in a home setting, Medicare is exploring the idea of providing better care to people in the most appropriate setting using new technologies and electronic medical records to manage patients better.

Mr. SARBANES. I have recently run into a number of pharmacists and they have sort of raised this issue of how reimbursement works for the services that they assert they are providing that are not covered at all, and that is an example of frontline interaction with patients. It can make a huge difference in a lot of patients who are very dependent on the pharmacist for giving them some guidance. Can you talk about whether there is any look at sort of what the benefit structure and reimbursement is in that arena?

Ms. BAICKER. So without speaking specifically to pharmacists, I don't know as much about that issue as I would like to, I think having bigger teams of caregivers from doctor to nurse to pharmacist to home visitation would promote looking at sort of the whole patient, that disease management is not about any of the silos, and the siloed reimbursement that we do that under-reimburses some and overreimburses others really discourages the team-based approach to being responsible for a group of patients' outcomes among a group of providers that we give some more flexibility and say, here is who would really help this patient, it is this kind of provider. Let us put more resources towards that and let us take resources away from this type of patient.

Mr. SARBANES. Thanks very much. I will yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the chair emeritus of the full committee, Mr. Barton, 5 minutes for questions.

Mr. BARTON. Mr. Chairman, I don't have any questions. I will be happy to yield my time to anybody who wishes it.

Mr. PITTS. Mr. Lance?

Mr. LANCE. Thank you, and good morning to you all. It is a very interesting panel and a very important issue.

Some raise concerns about the escalating costs of new medical treatments in the context of the Nation's growing entitlement program costs, and we are all concerned about that obviously. Dr. Baicker, you note in your testimony that technological innovation raises the stakes in this debate. There are different ideological approaches to controlling costs, especially those associated with new treatments. Some choose to develop a framework in the health care reform law whereby the government would choose value rather than the consumer or the patient by implementing the governmentally driven model such as IPAB, and of course, IPAB is something that I oppose and many oppose on a bipartisan basis, particularly here in the House.

Could you speak to the value of a cost-sharing framework where Medicare enrollees would choose services and treatments if they were spending their own funds?

Ms. BAICKER. I agree that the rise in costs raises the stakes in that there are new treatments all the time that could provide really valuable benefits, and there are new ways to spend money that might not provide high health value, and if we were to cover every possible service that might benefit every possible beneficiary even a little bit with public funds, because of innovation, that could be more than 100 percent of GDP. So there has to be some way to allocate those resources, and I would argue that the more flexible that is, the more patients have some choices about the bundle of care that is right for them. I think we can't afford to be subsidizing the use of low-value care for high-income beneficiaries but it is very hard to write down a set of rules that says this is the type of service that is worth it and this isn't.

Mr. LANCE. Thank you. Would anyone else on the panel like to comment? Dr. Neuman?

Ms. NEUMAN. Well, I would just say it is so hard for patients to make these decisions, particularly when they are sick and they are scared. You know, you think of somebody who has just been diagnosed with some form of cancer and they go to their doctor and their doctor says there are three treatment options for you, and I think you should do this one because I am the expert, and the doctor rarely says that one is going to be the more expensive one and it is a new technology and all that other stuff. When you are scared, you go to the expert and you are rarely thinking about what is the cost to me, I really want to live and survive this disease.

Mr. LANCE. Thank you. Mr. Miller.

Mr. MILLER. What we are struggling about is a decision between the locus of decision making and changing the degree to which it currently resides. I think the better way to go is an approach toward more delegated but informed decision making with greater involvement, not maximum involvement, not unrealistic at the beneficiary and consumer level. We need to remember that seniors are allowed to manage the rest of their budgets without Washington telling them what is high value and low value. They have other income that they have to spend on other things and we don't say here is what your benefit structure is for your food, your housing, the other things you are going to spend it on. That can be driven

to unrealistic levels, and that is why we have the protections for low-income seniors.

The other thing to remember is that the default option often is not to do the most high-level perfectly calibrated value judgments in what we cover. Instead, what we do—and this is the Affordable Care Act—we reduce reimbursement across the board and pretend that we haven't taken away anyone's benefits when we have actually hollowed them out by doing it through the pass-through providers-less.

Mr. LANCE. I thank you. Let me say that I hope as we move forward, we might review some of the provisions of the Affordable Care Act. Obviously, I did not support it, but moving forward, I hope that we have the opportunity to review, for example, IPAB, and I believe, based on my observation, that there is a bipartisan consensus, particularly here in the House, that we should revisit that issue.

Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Texas, Mr. Green, for 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman, for holding the hearing, and I thank our witnesses for appearing.

We hear a lot from my colleagues on the Republican side that there needs to be more cost sharing in the Medicare program. Cost sharing makes sense, making sure beneficiaries have skin in the game and good policy. That is why we already do it. Seniors spend a lifetime of working to pay into the system. Once beneficiaries are eligible, they rack up thousands of dollars in bills due to cost sharing. If we continue to decrease the portion paid by the government, more and more future retirees will be unable to pay their bills. With the system remaining solvent until 2026, we have the time to make sure we can do it right. Benefit redesign and more cost shifting to beneficiaries become necessary but the devil is in the details. For instance, we should look at a value-based system and a system where higher-value procedures the government should be willing to pay more for lower-value procedures but beneficiaries should pay more. At the same time, we should focus on strengthening preventive care and improving quality outcomes, which save money now and later. Cost sharing and benefit redesign cannot happen alone, and it must be done carefully, and out-of-pocket expenses must be predictable and necessary health care must be high quality and low cost.

Dr. Neuman, is it necessary to approach cost sharing and benefit redesign with nuance, and can you explain in your testimony about the incentivizing adoption of high-value care and what kind of care would be high value?

Ms. NEUMAN. For reasons which you just described, I think it is very important to approach this with nuance. I think we have all three of us talked about the importance of maintaining and improving protections for people with low and modest incomes, and trying to make—adding catastrophic protection but moving together the pieces in between is complicated without shifting costs onto certain people. There seems to be a great deal of interest in moving people toward high-value care but deciding what is high value remains a challenge. So I think I would imagine we would all agree that there

are a lot of points of agreement including we should move very carefully given the importance of this program and the protections it provides.

Mr. GREEN. And I do think that even the private sector is moving to that. There was an article just recently about companies, employers coming together and saying in California this is—these are the standard prices and this is what we will pay; now, if you want a higher value, you are on your own, it is out of network so to speak. So maybe the market is actually doing that but it would help the market if we used Medicare because that is our national health care to be able to talk about it.

Ms. BAICKER. Well, I think it can go both ways. There are times when the market follows Medicare, and this could be a time where Medicare follows the market and learns from the best practices that are already taking place.

Mr. MILLER. We find that private plans and private markets, because they have to meet a bottom line, they have to satisfy their enrollees, they are in business every day competing with other people, they have to find that high value. They are motivated to do it. It is a lot harder in our system to do this politically. The idea that you are going to be voting every year in Congress on, well, what is the latest set of high-value calculations is not realistic in the same way delegating it to—well, somewhere in HHS and CMS they will figure it out and we will all be happy about that. Again, kind of transcends the bounds of what we have normally seen in the past.

Mr. GREEN. And I agree, and we know when we—a lot of have a change in how medicine is practiced is something we have already—everybody says oh, that is not the way it should be and we are always second-guessing.

Dr. Neuman, how has the Affordable Care Act added value to Medicare?

Ms. NEUMAN. Well, in a number of ways. I think one of the clearest ways it has helped is to slow the growth in Medicare spending so it will keep Medicare around for future generations. It will help to sustain the program for longer, and that is probably not something that has gotten a whole of attention. I think also it is putting in place delivery-system reforms to be tested which could have fundamental effect on the future of the delivery of care for maybe current generations but the future generations of Medicare beneficiaries. There are maybe dozens of delivery-system reforms that are being tested. Maybe all of them will not work. But to the extent that any of them are going to improve care and better coordinate care, that will make a fundamental shift.

Mr. GREEN. Well, I know I have only 29 seconds, but the medical-home issue—

Ms. NEUMAN. Medical home is a good example. There are a number of them.

Mr. GREEN. And also looking at the preventive care, and it just makes so much sense that if you are diabetic to have these annual Medicare exams to make sure. We know also that the lower your income, the less you are likely to go if it costs you money.

Ms. NEUMAN. Exactly, and of course, there is the infamous donut hole which creates enormous problems for people if they have those

high expenses, which will now be closed as a result of the Affordable Care Act.

Mr. GREEN. It is closing slower than I would like but it is closing. I yield back my time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from New York, Mr. Engel, 5 minutes for questions.

Mr. ENGEL. Thank you very much, Mr. Chairman. Let me first say that I would like to see a Medicare benefit structure that protects beneficiaries from catastrophic expenses, encourages the use of high-value services, and strengthens the financial protection for low-income beneficiaries, and having voted against the Ryan budget for the last 3 years, I will not support proposals that seek to cut Medicare benefits or dramatically increase vulnerable beneficiaries' out-of-pocket costs for vital health care services. As we try to transform the health care system into one that promotes prevention and early intervention, I worry, very much worry that proposals that include higher deductible and copayments could be a hindrance to this effort.

So Dr. Baicker, I like the example you gave earlier with diabetics. I fear both the human and cost implications if higher cost sharing for doctor's office visits resulted in, for example, a diabetic foregoing regular blood sugar monitoring and that eventually resulted in an expensive hospitalization and debilitating health care requirements. So let me ask you, Dr. Baicker, and also Dr. Neuman, can you elaborate on how increased cost sharing might have a negative impact on treatment adherence?

Ms. BAICKER. Yes. I think it is important that cost sharing be nuanced, as we all have said, and not crude, and just increasing cost sharing could drive people to forego care that has long-run payoffs, and we want to avoid that. That said, there is a lot of care that has really questionable health benefit that I think our system can't afford to subsidize. So the question is, can we lower the subsidies or increase the cost sharing or prices for care that doesn't produce that downstream benefit and use those resources to shore up services that have really high value, particularly for low-income beneficiaries, and I think it is hard to write down a set of rules that says this yes, this no, but I very much agree with your question that we need to subsidize that kind of care so that people don't forego things that would improve their health.

Mr. ENGEL. Thank you. Dr. Neuman, do you agree?

Ms. NEUMAN. Yes, I do agree. I mean, a very good example is the home health copay or coinsurance, which people have talked about, because Medicare does not apply copayment or coinsurance to these services. So who uses home health services? This is older, frailer women. Many have been to the hospital and are out. So a coinsurance would affect people who have many, many visits and it would probably discourage a lot of visits. Some of them may or may not be necessary but they are visits that have been ordered by a medical professional. So it would clearly either shift costs onto the oldest and frailest and/or reduce utilization, and some people think that is a good idea, but there are risks to doing something like that. The alternative approach is to think about ways of creating incentives for the providers of care to provide appropriate care so

that people don't get too much of what they don't need but they get what they do.

Mr. ENGEL. Thank you. I know that studies have looked at the impact of younger populations but I want to ask both of you, do either of you know of studies that have specifically looked at the impact increased cost sharing might have on rates of hospitalization with older and sicker populations like those served by Medicare?

Ms. BAICKER. There is one study that comes to mind immediately that looked at increasing the cost sharing for pharmaceuticals for a Medicare population that had wraparound coverage in California, and when you increase their copayments for drugs, they took fewer of them, but that was partially then offset by increased hospitalizations downstream and that increase in hospitalizations was concentrated among people who had multiple chronic conditions. It didn't completely offset the cost savings for the reduction in pharmaceutical use but those benefits accrued to different people because there were different insurers involved, so it is a great example of spillovers across silos and the importance of unifying insurance and care.

Ms. ENGEL. Thank you. Dr. Neuman, I agree with your written testimony, the statement in your written testimony that Medicare's current benefit designs are complicated, and for seniors lived on fixed incomes, it can be really difficult for them to accurately budget for health care costs given the various deductibles, premiums, copayments and coinsurance rates in Medicare. In May 2013, just a couple months ago, analysis by your organization, the Kaiser Family Foundation, found that 18 percent of seniors in my home State of New York are living in poverty under the supplemental poverty measure and they just simply cannot afford to pay more. So as we look at benefit redesign, can you elaborate on the benefit you seek to replacing coinsurance rates with copayments?

Ms. NEUMAN. Sure. The supplemental insurance measures higher because it takes into account health expenses, and so that is what people are incurring, which produces larger estimates of seniors in poverty. Copayments can be structured so that they are less onerous, so a great example is back to the home health care we just gave. Coinsurance could be an insurance on every visit which would build up and up and up over time. An alternative would be a copayment on an episode of care which would be fixed, more predictable and wouldn't penalize those who have extensive need for home health services.

Mr. ENGEL. And let me ask you a final question, either one. MedPAC's 2012 recommendations on benefit redesign included the recommendation that the Secretary of Health and Human Services have the authority to make value-based changes to Medicare's benefit design. So can you describe what this might look like with a real-world example, and why this would be of value in our rapidly changing health care system?

Ms. BAICKER. Sure. So home health, I think, is an interesting example because it is a really important benefit for millions of people but it has been subject to some fairly well publicized overuse, potentially even abuse, of extreme rates of utilization for populations where it might not have such a high benefit. If there were more careful delineation of the cases in which it actually benefited people

and they were protected from copayments or had reduced copayments for those cases versus patients where there are lots of alternatives that might do just as well for them and where the utilization is less warranted, you could then ensure that this vital benefit for some is protected by cutting back on overuse in other circumstances.

Mr. ENGEL. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. That concludes the questions of the members who are present. I am sure there will be more questions from members who are not here, and we will ask them to submit those. We will submit those to you in writing, and we ask the witnesses to please respond promptly. I remind the members that they have 10 business days to submit questions for the record, so they should submit their questions by the close of business on Friday, July 12. We have a unanimous consent request.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman. I ask unanimous consent to include in the record the AARP testimony that was given at Ways and Means on the issue of benefit restructuring.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. Very, very informational. Thank you very much for your testimony today. And without objection, the subcommittee is adjourned.

[Whereupon, at 11:50 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



Lee Saunders
President
Laura Reyes
Secretary-Treasurer

Vice Presidents

Ken Allen
Portland, OR
Henry L. Bayer
Chicago, IL

Ken Deitz, RN
San Dimas, CA

Greg Devereaux
Olympia, WA

Danny Donohoe
Albany, NY

David R. Fillman
Harrisburg, PA

Michael Fox
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Kathleen Garrison
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Mattie Harrell
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Statement for the Record by the

American Federation of State, County and Municipal Employees (AFSCME)

For the Hearing on

A 21st Century Medicare: Bipartisan Proposals

to

Redesign the Program's Outdated Benefit Structure

Before the

Subcommittee on Health

Committee on Energy and Commerce

U.S. House of Representatives

June 26, 2013

American Federation of State, County and Municipal Employees, AFL-CIO

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**Statement for the Record
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This statement is submitted on behalf of the 1.6 million workers and retiree members of the American Federation of State, County and Municipal Employees (AFSCME).

AFSCME is proud of labor's historic role in the creation of Medicare, a federal social insurance program that is indispensable to our country. When President Johnson signed Medicare into law on July 30, 1965, he spoke of its profound promise:

"No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts. And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country."

For today's 50 million Medicare beneficiaries and the millions who will depend on this program in the future, the need for Medicare to remain a bulwark against financial ruin, caused by the caprice of illness and disability, rings as true in 2013 as it did nearly five decades ago.

Changes to Medicare Should be Aimed at Improving Coverage, Not Deficit Reduction or to Pay For Replacing the Sustainable Growth Rate Payments to Doctors

Medicare benefit design must not be a diversion to disguise shifting costs onto beneficiaries or employers who provide retiree coverage or making health care unaffordable for the majority of seniors and individuals with disabilities. While the details may vary, the underlying premise of many benefit redesign proposals is to increase out-of-pocket costs for beneficiaries. The pretense of these proposals is that Medicare beneficiaries are over-insured and increased cost sharing is an appropriate means of limiting unnecessary health care services. As Congress looks at beneficiary cost sharing within the Medicare program, the focus must be on expanding benefits and reducing beneficiary costs.

Half of all people with Medicare live on incomes of less than \$22,000 per year. Medicare households spend 15% of income on health care costs compared to the just 5% spent by non-Medicare households. In short, Medicare beneficiaries are often forced to choose between making ends meet and getting the medical care they need. Increasing out-of-pocket health care costs for beneficiaries will jeopardize the health of seniors and individuals with disabilities who rely on Medicare.

Increasing beneficiary cost sharing (either directly or by constraining supplemental policies that cover Medicare cost sharing) is a misguided approach to benefit redesign because it will limit beneficiary access to necessary care. Building in extra costs and charges for beneficiaries is a blunt and inefficient tool for cutting costs. In reducing utilization, it will prevent beneficiaries from getting the appropriate care they need. This troubling implication is acknowledged by the Medical Payment Advisory Commission (MedPAC) in its June 2012 benefit redesign proposal. The National Association of Insurance Commissioners (NAIC) has strongly recommended against further cost sharing to Medicare supplemental insurance policies, known as Medigap plans, because of the harm to the health of beneficiaries and the Medicare program in the long run.¹

The classic RAND Health Insurance Experiment, which did not include Medicare beneficiaries, found that reduced use of services resulted primarily from participants deciding not to initiate care. But it reduced both needed and unneeded health care services. Once patients entered the health care system, cost sharing had a limited effect on intensity or cost of an episode of care. The study also found that the absence of cost sharing (free care) improved the control of treatable chronic diseases such as hypertension, and improved the mortality of patients, especially for the poorest patients in the experiment. The implication from this study is that reducing costs for treatable conditions can save lives and that cost sharing is an unreliable tool for reducing health care use.

It seems dubious at best (and potentially cruel at worst) to ask beneficiaries to second-guess their doctor's recommendations or to shoulder the full responsibility of evaluating the extent to which they need medical care in the first place. Increasing cost sharing does more harm than good for the very sick, for the old and for the poor. While asking beneficiaries to pay higher co-pays or coinsurance may reduce federal expenditures in the short run, it simply moves these costs from the government onto beneficiaries.

Increasing cost sharing focuses on the wrong problem as a means of curbing overall health care costs and is not likely to remedy high costs. As compared with other industrialized nations, our high medical spending is driven by high prices, not high utilization.² Raising the out-of-pocket costs on beneficiaries will not reduce high medical prices. Indeed, providers may increase prices if utilization drops.

Similarly, changing Medicare to a premium support plan is a benefit structure redesign that gives less and less purchasing power to beneficiaries. Even if one viewed a

¹ National Association of Insurance Commissioners, "Medicare Supplemental First Dollar Coverage and Cost Shares Discussion Paper" (October 2011).

² Gerard F. Anderson, Uwe E. Reinhardt, Peter S. Hussey, and Varduhi Petrosyan, "It's The Prices, Stupid: Why The United States Is So Different From Other Countries" *Health Affairs*, 22, no.3 (2003):89-105.

premium support plan as a form of competitive bidding, by breaking up the Medicare pool we are undermining the clout that seniors have in negotiating affordable prices with providers and insurers. Offering both private plans and traditional Medicare uses the promise of choice and the false lure of competition to disguise the diminishment of Medicare's function to deliver guaranteed benefits, pool resources and protect beneficiaries from unexpected health care costs.

An alternative form of premium support would provide coverage for a limited range medical services or pool of providers, but allow beneficiaries to pay for additional coverage or treatments. Some have proposed diluting Medicare's level of guarantee benefits and allowing higher-income beneficiaries to consume Medicare's current coverage – and with it the possibility of better health outcomes – through their own finances. This is a plan for rationed care, that divides the Medicare population by income, and undermines the foundation of Medicare to provide coverage regardless of a beneficiary's health status or income. Aside from the obvious problem of rationing care under Medicare, these proposals offer a new twist on what is often called balance billing. Under balance billing doctors would be allowed unfettered discretion to charge Medicare beneficiaries for covered treatment. Under this proposal, treatments and medical services now covered by Medicare would not be covered but still accessible for those able to pay the balance bill of whatever providers choose to charge.

The requirement that participating physicians cannot charge beneficiaries more than Medicare reimburses for all covered services and that non-participating physicians limit the additional charges for Medicare covered services, is particularly important for a population that cannot afford more cost sharing. Allowing unfettered balance billing will turn Medicare's promise of guaranteed benefits regardless of health status and income on its head. The new promise of Medicare under these proposals would be that after a lifetime of hard work, only the wealthy will have access to the miracles of modern medicine.

Conclusion

Medicare is an amazing success story – providing health and financial security to millions of Americans even during the worst economic crisis since the Great Depression. AFSCME urges Congress to reject proposals to redesign Medicare in a way that builds in extra cost sharing for beneficiaries. This would allow sick and older seniors and individuals with disabilities, who are on limited incomes, to be denied needed health care because of additional out-of-pocket costs.

While we oppose achieving short-run federal savings through beneficiary cost savings because such savings are shortsighted, we do support eliminating sweetheart deals for the pharmaceutical industry that lead to overpayments for prescription drugs. For example, when Congress enacted the Medicare Part D drug benefit, it prohibited Medicare from negotiating lower drug prices with drug companies. Ending this prohibition could save Medicare more than \$200 billion over 10 years. In addition, the Medicare Part D law resulted in a substantial drug manufacturer windfall because it ended the then-existing requirement that manufacturers pay rebates for beneficiaries who are eligible for both Medicare and Medicaid (known as dual eligible) and low-income Part D enrollees. Reinstating the rebates that were required before 2006 would ensure that taxpayers and the Medicare program do not overpay for Part D drugs.

We would be remiss if we did not point out that Medicare excludes the vital services that many seniors and individuals with disabilities need to maintain their independence – such as long-term supports and services. Medicare provides limited post-acute care and few Americans can

afford private long-term care insurance. Medicaid is by default the provider of long-term care services, but requires seniors and individuals with disabilities to impoverish themselves to get the services they need to complete life's daily activities. As America ages, the gaps in coverage for long-term care will further strain and challenge families, communities and our country. We urge the Committee to address this urgent and growing need for long-term supports and services.

In sum, Medicare has helped generations of Americans keep a toehold in the middle class. As Congress considers the adequacy of Medicare's benefit design, we urge you to reject proposals that seek to shift costs from the government onto beneficiaries. The goal of benefit redesign should be to ensure that benefits are adequate, not to achieve deficit reduction. Moreover, Congress must look for another way to pay for an adjustment to physician reimbursements that does not undermine the health of seniors and people with disabilities.

UNITED STATES HOUSE of REPRESENTATIVES
COMMITTEE on ENERGY & COMMERCE, SUBCOMMITTEE on HEALTH
HEARING on "A 21st CENTURY MEDICARE: BIPARTISAN PROPOSALS to REDESIGN
the PROGRAM'S OUTDATED BENEFIT STRUCTURE"

June 26, 2013

WRITTEN TESTIMONY SUBMITTED JOINTLY by
CALIFORNIA HEALTH ADVOCATES,
CENTER for MEDICARE ADVOCACY,
and MEDICARE RIGHTS CENTER

Mr. Chairman and Members of the Committee:

California Health Advocates, the Center for Medicare Advocacy, Inc., and the Medicare Rights Center are independent, non-profit organizations with extensive experience representing older adults and people with disabilities who rely on Medicare for basic health and economic security.

Our three organizations also served as consumer representatives to a subgroup of the Senior Issues Task Force (SITF) of the National Association of Insurance Commissioners (NAIC) tasked with reviewing a provision of the Affordable Care Act (ACA) relating to Medigap policies. We offer this testimony through our perspective as beneficiary advocates and members of this deliberative NAIC process that included a range of stakeholders.

In December 2012, as a result of the work of the NAIC subgroup, the NAIC strongly recommended against adding further cost-sharing to Medigap plans in a letter to the U.S. Department of Health and Human Services (DHHS).¹ In May 2013, DHHS accepted this recommendation, bringing the subgroup's deliberations to a final close.²

The research conducted by the subgroup roundly rejects the basic assumption that limited cost-sharing afforded by Medigap plans leads to overutilization of health care services. By way of the subgroup's conclusion, the NAIC rebuffed the notion that increased cost-sharing is an appropriate tool to limit unnecessary use of health care services. The subgroup concluded:

The proposals [to add cost-sharing to Medigap plans] focus on overutilization by beneficiaries but do not consider the potentially serious and unintended impacts for beneficiaries and the Medicare program. Namely, in response to increased costs, beneficiaries may avoid necessary services in the short-term that may result in worsening health and a need for more intensive care and higher costs to the Medicare program in the

¹ National Association of Insurance Commissioners letter to Secretary Sebelius (December 2012), available at: http://www.naic.org/documents/committees_b_sitf_medigap_ppaca_sg_121219_sebelius_letter_final.pdf

² Secretary Sebelius' May 28, 2013 letter to NAIC is available on the NAIC website at: http://www.naic.org/documents/committees_b_senior_issues_related_docs_sebelius_response_letter.pdf

long-term. In addition, research indicates that once beneficiaries seek care, doctors and other medical providers, not patients, generally drive the number and types of services delivered to beneficiaries. Further, the proposals do not address the fact that Medicare determines which services are reimbursed and therefore, by law, covered by Medigap...³

The NAIC determined that increased cost-sharing in Medigap plans was likely to prohibit the use of both necessary and unnecessary health care services. Both the Medicare Payment Advisory Commission (MedPAC) and the Congressional Budget Office (CBO) have acknowledged this same concern in reference to proposals that increase beneficiary cost sharing.⁴

Although this NAIC subgroup focused on potential changes to Medigap plans, the research reviewed and the resulting conclusions are applicable to a range of reform proposals, including the subject of this testimony—Medicare cost sharing and benefit design. Through our work representing people with Medicare, we know that the Medicare program has significant, complicated out-of-pocket costs and can be simplified. With the aim of securing savings, however, restructuring Medicare cost sharing is likely to both unfairly redistribute costs to beneficiaries with fixed incomes and limit access to needed health care services. Faced with higher health care costs, many beneficiaries would be forced to self-ration needed care.

While taking a measured look at the program through the lens of improving beneficiary well-being as opposed to securing savings would be a welcome exercise, we believe that the following Medicare proposals would have harmful, unintended consequences for beneficiaries:

- Benefit redesigns that would redistribute cost burdens;
- Prohibiting or taxing Medigap “first-dollar coverage”;
- Increasing the share of and/or further means-testing Medicare premiums;
- Raising the age of Medicare eligibility;
- Adding or increasing costs for services, such as home health benefits; and
- Premium support or competitive bidding models that weaken Traditional Medicare.

Each of these proposals might save federal dollars in the short run, but would do so through significant cost-shifting to beneficiaries. At the same time, none of these proposals address the long-term challenge of systemic health care inflation that threatens our nation’s ability to provide affordable health care, both in public and private markets.

Our organizations recognize the need to reduce health care spending system-wide. We support Medicare savings interventions that eliminate wasteful spending and build on the efficiencies of

³ National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, “Medicare Supplemental First Dollar Coverage and Cost Shares Discussion Paper” (October 2011), available at:

http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf

⁴ MedPAC, “Report to the Congress: Medicare and the Health Care Delivery System” (June 2012), available at:

http://www.medpac.gov/documents/Jun12_EntireReport.pdf; Congressional Budget Office, “Budget Options Volume 1: Health Care” (December 2008), page 155, available at: <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/99xx/doc9925/12-18-healthoptions.pdf>

the ACA. At a time when Medicare spending is growing at historically low rates, and innovations through the ACA hold promise of continuing to keep costs down, we oppose implementing unwise policies that seek federal savings by way of cost-shifting on the backs of Medicare beneficiaries.⁵

According to DHHS, Medicare cost growth slowed dramatically in recent years to levels “unprecedented in the history of the Medicare program.”⁶ Additional analysis by the S&P Dow Jones Indices illustrates that “...health care costs have decelerated over the past few years, and Medicare costs have decelerated more than other health costs.”⁷

The recent release of the 2013 Medicare Trustees Report affirms an improved fiscal outlook for the Medicare program. The trustees find that the Hospital Insurance Trust Fund is solvent through 2026—two years later than previously predicted.⁸ While some of the health care cost growth slowdown is attributable to the continued effects of the economic downturn, research indicates that much of this change is structural meaning that slowed growth is likely to persist.⁹

Due in part to these recent projections, we believe that there is no justification for policy interventions that would shift added costs to people with Medicare. We reject proposals to redistribute Medicare cost sharing under the guise of securing federal savings. Under the proposed concepts, too many would lose access to affordable coverage, and too many would be discouraged from seeking needed care, threatening the basic health and economic security of our nation’s older adults and people with disabilities.

Current Expenses and Coverage for Medicare Beneficiaries

Before considering proposals that would alter what Medicare beneficiaries pay for their health care, it is necessary to understand the current fiscal challenges faced by this population. The vast majority of Medicare beneficiaries have low or moderate incomes. In 2012, half of all Medicare

⁵ Office of the Assistant Secretary for Planning and Evaluation, “Growth In Medicare Spending Per Beneficiary Continues To Hit Historic Lows” (DHHS: January 2013), available at: <http://aspe.hhs.gov/health/reports/2013/medicarecostgrowth/ib.cfm>; DHHS, “Press release:” Trustees report shows reduced cost growth, longer Medicare solvency” (May 2013), available at: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-05-31.html?DLPage=1&DLSort=0&DLSortDir=descending>.

⁶ Office of the Assistant Secretary for Planning and Evaluation, “Growth In Medicare Spending Per Beneficiary Continues To Hit Historic Lows” (DHHS: January 2013), available at: <http://aspe.hhs.gov/health/reports/2013/medicarecostgrowth/ib.cfm>.

⁷ S&P Dow Jones Indices, “Press Release: Deceleration in Annual Growth Rate for All Nine Indices in June 2012, According to the S&P Healthcare Economic Indices” (January 2012); J. Weisenthal, “Peter Orszag’s Chart Of The Year Could Change Everything You Think About Healthcare And The Federal Budget” (*Business Insider*: December 2012), available at: <http://www.businessinsider.com/peter-orszag-chartshows-medicare-costs-slowing-2012-12>.

⁸ The Board of Trustees, “2013 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Supplemental Medicare Insurance Trust Fund” (May 2013), available at: <http://downloads.cms.gov/files/TR2013.pdf>.

⁹ A. Ryu, T. Gibson, McKeller, M.R., and M.E. Chernew, “The Slowdown in Health Care Spending in 2009-11 Reflected Factors Other Than the Weak Economy and Thus May Persist” (*Health Affairs*: May 2013); D. Cutler and N.R. Sahni, “If Slow Rate of Health Care Spending Growth Persists, Projections May Be Off \$770 Billion” (*Health Affairs*: May 2013).

beneficiaries had annual incomes below \$22,500. And half of beneficiaries had just \$77,500 or less in personal savings.¹⁰

The cost of living varies considerably for older adults depending on housing status, health status and geographic location. For instance, an older adult in good health who rents a home in Chester County, Pennsylvania requires an annual income of approximately \$26,650 to cover expenses, accounting for only the most basic needs: housing, food, transportation, health care and other essentials, like clothing and toiletries. Yet, the same older renter living in Dallas County, Texas needs an estimated \$28,500 to make ends meet.¹¹

Medicare beneficiaries pay relatively more than other groups for their health care. Medicare households have a lower average budget than the average household (about \$30,800 vs. \$49,600 respectively) but devote a substantially larger share of their income to medical expenses than does the average household (15% vs. 5% respectively).

Already faced with high health care costs, many people with Medicare are forced to choose among basic needs, such as buying groceries or seeing the doctor for a persistent cough. Recent analysis on poverty trends among older adults suggests that these harsh choices are commonplace among our nation's retirees. One third of older adults live on incomes below 200% of the traditional measure of poverty; whereas, one half live on incomes below 200% of poverty according to a supplemental measure developed by the U.S. Census Bureau that accounts for out-of-pocket health care costs.¹²

Medicare beneficiaries also tend to have greater health needs than other groups. On the whole, people with Medicare have multiple and significant health needs—40% of beneficiaries have three or more chronic health conditions, and more than one quarter of beneficiaries (27%) report being in fair or poor health. Nearly one in four people with Medicare live with a cognitive or mental impairment, requiring extensive, ongoing care.¹³

Because the current Medicare benefit is not overly generous and requires considerable out-of-pocket costs, approximately 90% of Medicare beneficiaries have some type of coverage that supplements Medicare. Three quarters of the Medicare population has coverage through Traditional Medicare. Among this group, most have retiree wrap-around benefits through former

¹⁰ J. Cubanski, "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicarebeneficiaries-costs-and-service-use-testimony.pdf>.

¹¹ Wider Opportunities for Women, "Economic Security Database: Elder Economic Security Standard™ Index for Chester County, Pennsylvania" (2013), available at: <http://www.basiceconomicsecurity.org/>; Wider Opportunities for Women, "Economic Security Database: Elder Economic Security Standard™ Index for Dallas County, Texas" (2013), available at: <http://www.basiceconomicsecurity.org/>.

¹² Kaiser Family Foundation, "A State-by-State Snapshot of Poverty Among Seniors: Findings From Analysis of the Supplemental Poverty Measure" (May 2013), available at: <http://kff.org/medicare/issue-brief/a-state-by-state-snapshot-of-poverty-among-seniors/>.

¹³ J. Cubanski, "An Overview of the Medicare Program and Medicare Beneficiaries' Costs and Service Use" (Kaiser Family Foundation: February, 2013), available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/an-overview-of-the-medicare-program-and-medicarebeneficiaries-costs-and-service-use-testimony.pdf>.

employment (41%) and others secure supplemental insurance through Medigap plans (21%). Medicaid provides wrap-around coverage to about one in five (21%), and still a notable share of beneficiaries with Traditional Medicare (17%) lack supplemental coverage altogether. In addition, about one quarter (27%) of beneficiaries are covered through private Medicare Advantage plans as opposed to Traditional Medicare.¹⁴

Many of these supplemental types of insurance, in effect, limit out-of-pocket expenses. As noted by several members of Congress in a “Dear Colleague” letter highlighting the important role played by Medigap plans, “Medicare’s current structure puts beneficiaries who are the poorest and the sickest in a position where, without supplemental coverage, a severe chronic condition or catastrophic event could bankrupt them.”¹⁵ Even with these supplemental coverage options, people with Medicare lack coverage for particular services, including most long-term care services and dental care.

Most Medicare beneficiaries cannot absorb more costs without facing significant hardship. To borrow a crude metaphor, Medicare beneficiaries already have too much “skin in the game,” and as a group, are very aware of the high cost of health care services based on the bills they receive and Medicare’s summary notice of payment.

Proposals to Redesign Medicare’s Benefit Structure

Over the last few years, there have been several proposals offered by various lawmakers, commissions and other entities that seek to alter Medicare’s benefit structure. Although they have been offered within the context of debt and deficit reduction, some proposals claim to have the plight of Medicare beneficiaries firmly in mind. These proposals appear benign on their face in that they simplify Medicare’s structure; however, upon closer scrutiny, they merit significant concern because they increase beneficiaries’ costs and thereby limit their access to care.

In its June 2012 Report to Congress, MedPAC made recommendations to alter the Traditional Medicare benefit package, including redistributing cost-sharing through the use of tiered copayments, coinsurance and a combined deductible for Medicare Parts A and B, along with an out-of-pocket maximum for beneficiaries in Traditional Medicare. For illustrative purposes, not as a recommendation, MedPAC modeled a \$500 combined deductible, varying copayments and a \$5,000 spending limit, along with a 20% surcharge on supplemental plan premiums.¹⁶

Various other proposals to restructure the Medicare benefit contain similar elements, including: creating a single, combined deductible for Parts A and B; a uniform 20% coinsurance rate or

¹⁴ Neuman, Patricia, “Rethinking Medicare’s Benefit Design: Opportunities and Challenges” (Kaiser Family Foundation: June 2013), available at: <http://docs.house.gov/meetings/IF/IF14/20130626/101043/HHRG-113-IF14-Wstate-NeumanP-20130626.pdf>.

¹⁵ “Some Facts About Private Medicare Supplemental Insurance” by Reps. Terry, Blackburn and Latham (May 22, 2013), available at: <http://naifa.typepad.com/files/1305terryblackburnlatham-medigapsupport-pdf.pdf>.

¹⁶ MedPAC, “Report to the Congress: Medicare and the Health Care Delivery System” (June 2012), available at: http://www.medpac.gov/documents/jun12_EntireReport.pdf.

modified copayments for particular services; an out-of-pocket cap on beneficiary expenses; and other piecemeal proposals, such as introducing home health copayments, and/or modified beneficiary out-of-pocket caps and/or cost sharing determined on the basis of income.¹⁷

Often proposals to redesign Medicare's benefits are coupled with proposals to restrict Medigap "first-dollar coverage." Medicare supplemental insurance policies, also known as Medigap plans, are individual standardized insurance policies designed to fill some of the coverage gaps of Traditional Medicare. In exchange for a monthly premium, these policies offer financial security and protection against high and sporadic out-of-pocket costs for one in four Medicare beneficiaries.¹⁸ Policies that provide coverage for Medicare cost-sharing once Medicare has paid its portion are sometimes referred to as providing "first-dollar coverage."

Economic and Health Risks Posed by Redistributing Medicare Cost Sharing

Proposed Changes to Medicare Cost Sharing Shifts Costs to Beneficiaries

At first glance, combining the Part A and B deductibles and adding a catastrophic cap on out-of-pocket expenses seems like a credible concept. While details are lacking in most proposals, the broad outlines of those currently under discussion would increase costs for most people, and significantly so for those whom can least afford it. Some of these proposals purport to operate under the premise of "budget neutrality," or claim "no change in beneficiaries' aggregate cost-sharing liability."¹⁹ Yet, changing cost-sharing structures in the manner proposed redistributes the burden of health care costs onto the most vulnerable, including those with low- and moderate-incomes and those with persistent and chronic health needs.²⁰

In particular, individuals who are "near poor"—beneficiaries with incomes too high to qualify for low-income programs but still living on limited incomes—are most at risk. Additional upfront costs of a higher deductible for Part B services as well as any higher ongoing costs, such as new and/or higher coinsurance amounts, will make necessary care unaffordable and lead many people to forego critical care.

¹⁷ National Commission on Fiscal Responsibility and Reform, *The Moment of Truth* (December 2010), available at: http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf; The Moment of Truth Project, *A Bipartisan Path Forward to Securing America's Future* (April 2013), available at: <http://www.momentoftruthproject.org/publications/bipartisan-path-forward-securing-americas-future>; Berenson, B., Holahan, J. and S. Zuckerman, "Can Medicare Be Preserved While Reducing the Deficit?" (Urban Institute, March 2013), available at: <http://www.urban.org/publications/412759.html>; J. Gruber, *Proposal 3: Restructuring Cost Sharing and Supplemental Insurance for Medicare* (The Hamilton Project, February 2013), available at: http://www.brookings.edu/~media/research/files/papers/2013/02/hp%20budget%20papers/hp_15waysfedbudget_prop3.pdf; Bipartisan Policy Center, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment* (April 2013), available at: <http://bipartisanpolicy.org/library/report/health-care-cost-containment>.

¹⁸ Kaiser Family Foundation, "Medigap: Spotlight on Enrollment, Premiums and Recent Trends" (February 2013), available at: <http://www.kff.org/medicare/upload/8412.pdf>.

¹⁹ MedPAC, "Report to the Congress: Medicare and the Health Care Delivery System" (June 2012), available at: http://www.medpac.gov/documents/Jun12_EntireReport.pdf.

²⁰ Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending" (November 2011), available at: <http://www.kff.org/medicare/upload/8256.pdf>.

The Kaiser Family Foundation issued a 2011 report analyzing the impact of a Medicare redesign plan modeled on one offered by Erskine Bowles and Alan Simpson (Bowles-Simpson), co-chairs of the National Commission on Fiscal Responsibility and Reform.²¹ The study shows that 71% of beneficiaries in Traditional Medicare would have higher out-of-pocket spending—even with a spending cap—and only 5% would have lower out-of-pocket spending.²² Similarly, under MedPAC's analysis of their illustrative benefit redesign package, at least 20% of beneficiaries would pay an additional \$250-\$999 per year; their proposal coupled with a surcharge on Medigap plans would lead to 70% paying additional costs within this range.²³

A second iteration of the Bowles-Simpson plan made attempts to mitigate the known harms of this significant cost shifting by suggesting a lower deductible for individuals living below 200% of the federal poverty level and introducing an income-related out-of-pocket cap, an approach credited to MIT economist Jonathan Gruber.²⁴ The Bipartisan Policy Center makes similar attempts through the exemption of physician visits from the combined Medicare Part A and Part B deductible and an increase in income eligibility for low-income subsidy programs.²⁵

Yet, it is important to note that these attempts to soften the self-rationing effect of added cost shifting introduce further complexity to the Medicare program and undermine one of the stated goals of proposals that seek to restructure Medicare cost sharing: a more streamlined, simplified benefit. Given our experience counseling people with Medicare, we know that complicated rules and differential treatment creates needless confusion and strain for older adults and people with disabilities.

Income-relating a newly introduced out-of-pocket cap or deductibles would only serve to further complicate the program and is likely to increase administrative expenses. And while well intentioned, elements of these proposals intended to mitigate harm to lower income individuals beg the question: given the well-documented risk of added cost shifting and the complexity required to prevent resulting harms, is this policy approach a worthwhile one?

Stated attempts by the Bipartisan Policy Center and others to strengthen Medicare low-income protections for beneficiaries are worthwhile endeavors. In their current form, such protections do not fully extend to those who cannot afford to pay for necessary health care services. We believe

²¹ The Bowles-Simpson model included a unified Part A and B deductible of \$550, 20 percent coinsurance on most Medicare-covered services, and a \$5,500 annual limit on out-of-pocket spending.

²² Kaiser Family Foundation, "Restructuring Medicare's Benefit Design: Implications for Beneficiaries and Spending" (November 2011), available at: <http://www.kff.org/medicare/upload/8256.pdf>.

²³ MedPAC Presentation, "Reforming Medicare's Benefit Design" (March 2012), slide 10, available at: <http://www.medpac.gov/transcripts/benefit%20design%20mar2012%20public.pdf>.

²⁴ The Moment of Truth Project, A Bipartisan Path Forward to Securing America's Future (April 2013), available at: <http://www.momentoftruthproject.org/publications/bipartisan-path-forward-securing-america's-future>; J. Gruber, Proposal 3: Restructuring Cost Sharing and Supplemental Insurance for Medicare (The Hamilton Project, February 2013), available at: http://www.brookings.edu/~media/research/files/papers/2013/02/thp%20budget%20papers/thp_15waysfedbudget_prop3.pdf.

²⁵ Bipartisan Policy Center, A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment (April 2013), available at: <http://bipartisanpolicy.org/library/report/health-care-cost-containment>.

that any attempt to restructure Medicare cost sharing must begin with the modernization and broad application of these critical low-income protections.²⁶

Cost-Shifting to Beneficiaries Limits Access to Necessary Care

While increased cost-sharing poses significant financial risks for beneficiaries, particularly for those living on low- and moderate-incomes, it is also shown to limit access to necessary health care services. This was a primary finding of the NAIC subgroup convened to explore adding cost-sharing to specific Medigap plans on which our organizations served.

Pursuant to the ACA, the NAIC was directed to “review and revise the standards for benefits in Medigap Plan C and Plan F” and to update those standards to include cost-sharing, if practicable, so as to “encourage the use of appropriate physicians’ services...”²⁷ Toward this end, the NAIC convened the Medigap PPACA (B) Subgroup that included state insurance regulators, insurers and trade associations, consumer advocates and other Medicare experts. This subgroup spent almost two years reviewing available literature on cost-sharing and patient behaviors.²⁸ In addition, mid-way through its deliberations, the NAIC subgroup issued a discussion paper on more expansive proposals to diminish Medigap coverage and increase Medicare cost-sharing.²⁹

Based on mistaken notions that protection from out-of-pocket costs causes “overuse” of services, Medigap policies have been singled out by some policymakers who aim to either: 1) add a surcharge or tax to policies that offer first-dollar coverage; or 2) impose a deductible and limited coverage of additional cost-sharing, essentially prohibiting first-dollar coverage outright. Proposals to redistribute the burden of Medicare cost sharing, such as the one offered by MedPAC and Bowles-Simpson, often couple combining the Medicare Part A and B deductibles with restrictions on Medigap benefits or by increasing the cost of owning a Medigap plan. Some proposals would entail applying restrictions and/or increased costs on both current and future beneficiaries raising legal issues for insurance policies that are guaranteed renewable.

The subgroup’s research demonstrates that cost-sharing has dubious utility in holding down health care spending and can actually lead to increased total spending on health care when people forego medically necessary services. For example, a major Harvard School of Public

²⁶ For a more detailed explanation of our joint recommendations on strengthening Medicare low-income programs, see: California Health Advocates, Center for Medicare Advocacy, Inc., Medicare Rights Center, “Testimony on Strengthening Medicare for Seniors: Understanding the Challenges of Traditional Medicare’s Benefit Design” (April 2013), available at: <http://www.medicarerights.org/pdf/energy-commerce-testimony-041113.pdf>.

²⁷ Patient Protection and Affordable Care Act, §3210.

²⁸ National Association of Insurance Commissioners, “Medigap PPACA (B) Subgroup” webpage, available at: http://www.naic.org/committees_b_sitf_medigap_ppaca_sg.htm; see under heading “Cost-sharing Research and Literature” for summary of much of this literature (as of June 2011) available at: http://www.naic.org/documents/committees_b_senior_issues_110628_summary_dist_research.pdf.

²⁹ National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, “Medicare Supplemental First Dollar Coverage and Cost Shares Discussion Paper” (October 2011), available at: http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf.

Health review of the research on cost-sharing made several conclusions about its utility in controlling health care costs, including: “We do not know if increased patient cost-sharing would reduce the growth in total national health care spending;” “Increased cost-sharing disproportionately shifts financial risk to the very sick;” “Low-income older adults with chronic conditions are at increased risk for poor health outcomes due to increased cost-sharing.”³⁰

Due in part to these findings, in a letter to DHHS the NAIC concluded, “We were unable to find evidence in peer-reviewed studies or managed care practices that would be the basis of nominal cost-sharing designed to encourage the use of appropriate physicians’ services. Therefore, our recommendation is that no nominal cost-sharing be introduced to Plans C and F.”³¹

In addition, the NAIC letter stated, “We do not agree with the assertion being made by some parties that Medigap is the driver of unnecessary medical care by Medicare beneficiaries. As you are aware, Medigap plans pay benefits only after Medicare has determined that the services are medically necessary and has paid benefits. Medigap cannot alter Medicare’s coverage determination and the assertion that Medigap coverage causes overuse of Medicare services fails to recognize that Medigap coverage is secondary and that only Medicare determines the necessity and appropriateness of medical care utilization and services.” As noted above, in a letter dated May 28, 2013, Secretary Sebelius accepted NAIC’s recommendations.³²

Our organizations strongly support the NAIC’s determination. The conclusions drawn by this subgroup are applicable not only to Medigap reform proposals, but also to proposals that would increase beneficiary out-of-pocket costs, including the frameworks noted above that would redistribute the burden of Medicare cost sharing.

Conclusion

We remain deeply concerned about the effects of further cost-shifting onto people with Medicare, and we believe these proposals pose substantial risks to the health and economic security of Medicare beneficiaries, namely those with low- and modest-incomes and people with significant health needs. We acknowledge, however, that we must find savings in the Medicare program to sustain this guaranteed health benefit for future generations.

Towards this end, we support prudent cost containment designed to solve the true threat to our nation’s fiscal health: rising health care costs system-wide. To realize this goal, we endorse cost-saving solutions that eliminate wasteful spending and promote the delivery of high value care—

³⁰ Katherine Swartz, “Cost-Sharing: Effects on Spending and Outcomes” (December 2010), Robert Wood Johnson Foundation Research Synthesis Report No. 20, available at: http://www.naic.org/documents/committees_b_senior_issues_110628_rwjf_brief.pdf.

³¹ National Association of Insurance Commissioners letter to Secretary Sebelius (December 2012), available at: http://www.naic.org/documents/committees_b_sitf_medigap_ppaca_sg_121219_sebelius_letter_final.pdf.

³² Secretary Sebelius’ May 28, 2013 letter to NAIC is available on the NAIC website at: http://www.naic.org/documents/committees_b_senior_issues_related_docs_sebelius_response_letter.pdf.

meaning better quality at a lower price. Proposals our organizations support include: reduction of wasteful spending on drugs, medical equipment and private health plans, and advancing Medicare delivery system reforms made possible by health reform.³³

We look forward to working with the Committee and members of Congress to examine additional cost-saving options in the Medicare program that simultaneously address the systemic issue of rising health care costs that concern not only Medicare, but also to the private health insurance market. We implore you to reject proposals that fail to address this systemic issue and instead achieve only short-term savings by shifting more health care costs to people with Medicare. As such, we ask that you carefully weigh the significant risks posed to Medicare beneficiaries by the proposals discussed above and we urge you to steer clear of these models.

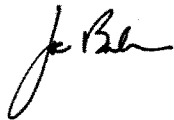
We appreciate this opportunity to submit these comments.



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³³ For a more detailed explanation of our joint recommendations on cost containment, see: California Health Advocates, Center for Medicare Advocacy, Inc., Medicare Rights Center, "Testimony on Strengthening Medicare for Seniors: Understanding the Challenges of Traditional Medicare's Benefit Design" (April 2013), available at: <http://www.medicarerights.org/pdf/energy-commerce-testimony-041113.pdf>.

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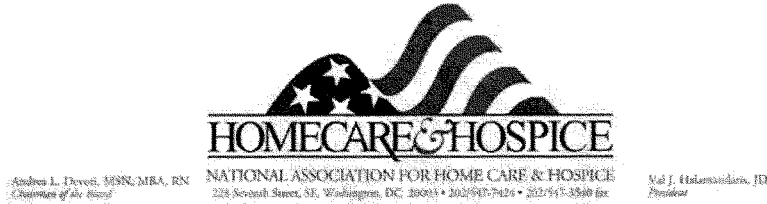
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STATEMENT SUBMITTED BY

**ANDREA DEVOTI, CHAIR, NATIONAL ASSOCIATION FOR HOME CARE &
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TO THE

HOUSE ENERGY AND COMMERCE SUBCOMMITTEE ON HEALTH

JUNE 26, 2013

The National Association for Home Care & Hospice (NAHC) is the leading association representing the interests of the home care and hospice community since 1982. Our members are providers of all sizes and types from the small, rural home health agencies to the large national companies, including government-based providers, nonprofit voluntary home health agencies and hospices, privately-owned companies, and public corporations. NAHC has worked constructively and productively with Congress and the regulators for three decades, offering useful solutions to strengthen the home health and hospice programs.

As the House Energy and Commerce Subcommittee on Health examines proposals to redesign Medicare's benefit structure, NAHC appreciates this opportunity to provide our views. Some policymakers have suggested adding copayments for Medicare home health and hospice services as a means of both reducing the deficit and preventing overutilization of home health and hospice services.

Congress eliminated the home health copayment in 1972 for the very reasons it should not be resurrected now. The home health copayment in the 1960s and 1970s deterred Medicare beneficiaries from accessing home health care and instead created an incentive for more expensive institutional care. Reinstating the home health copay today would undo the progress made in efforts to reduce unnecessary hospitalizations and nursing home stays.

Moreover, home health services and hospice care already have the highest cost-sharing in Medicare. On a daily basis, millions of spouses, family, friends, and community groups

contribute the equivalent of billions of dollars worth of care and support to keep their loved ones at home. Further, care in the home means that the Medicare beneficiary provides all the financial support in terms of room and board that are otherwise paid for by Medicare and Medicaid in an institutional setting.

Numerous studies have concluded that a copay can discourage use of necessary and beneficial care, resulting in the deterioration of a patient's condition and ultimately leading to higher costs for the Medicare program through acute care interventions in higher cost settings. With hospice patients, barriers to comfort at the end of life add both avoidable costs and avoidable pain.

We respectfully submit that Congress should oppose any copay proposal for Medicare home health and hospice services.

HOME HEALTH CARE

Proposals to impose a home health copay should be rejected for the following reasons:

- **Home health copayments would create a significant barrier for those in need of home care, lead to increased use of more costly institutional care, and increase Medicare spending overall.** The Urban Institute's Health Policy Center found that home health copays "...would fall on the home health users with the highest Medicare expenses and the worst health status, who appear to be using home health in lieu of more expensive nursing facility stays."ⁱ Similarly, a study in the *New England Journal of Medicine* found that increasing copays on ambulatory care decreased outpatient visits, leading to increased acute care and hospitalizations, worse outcomes, and greater expense.ⁱⁱ The same adverse health consequences and more costly acute care and hospitalizations would likely result from the imposition of a home health copay. The National Association of Insurance Commissioners concluded that beneficiaries, in response to increased cost sharing, "may avoid necessary services in the short term that may result in worsening health and a need for more intensive care and higher costs for Medicare in the long run."ⁱⁱⁱ Studies have shown that Medicaid copays can backfire with beneficiaries avoiding care leading to higher Medicaid overall costs.^{iv} The Veterans Administration recently eliminated copays for in-home video telehealth care to prevent avoidable hospitalizations of veterans.^v According to an analysis by Avalere, a home health copayment could increase Medicare hospital inpatient spending by \$6-13 billion over ten years.^{vi}
- **The burden of a home health copayment would disproportionately impact the most vulnerable—the oldest, sickest, and poorest Medicare beneficiaries.** About 86 percent of home health users are age 65 or older, 63 percent 75 or older, and nearly 30 percent 85 or older. Sixty-three percent are women.^{vii} Home health users are poorer on average than the Medicare population as a whole. Home health users have more limitations in one or more activities of daily living than beneficiaries in general.^{viii} The Commonwealth Fund cautioned that "cost-sharing proposals, such as a copayment on Medicare home health services, could leave vulnerable beneficiaries at risk and place an inordinate burden on those who already face very high out-of-pocket costs."^{ix}

- **Most people with Medicare cannot afford to pay more.** In 2010, half of Medicare beneficiaries—about 25 million seniors and people with disabilities—lived on incomes below \$22,000, just under 200 percent of the federal poverty level.^x Medicare households already spend on average 15 percent of their income on health care costs, three times as much as the non-Medicare population.^{xi}
- **Low-income beneficiaries are not protected against Medicare cost sharing.** Eligibility for assistance with Medicare cost sharing under the Qualified Medicare Beneficiary (QMB) program is limited to those with incomes below 100 percent of poverty (\$11,412 for singles, \$15,372 for couples) and non-housing assets below just \$6,940 for singles and \$10,410 for couples. In sharp contrast, eligibility for cost sharing assistance for individuals under age 65 is set at 138 percent of poverty, with no asset test. Even among Medicare beneficiaries eligible for QMB protection, only about one-third actually have it.^{xii}
- **Individuals receiving home care and their families already contribute to the cost of their home care.** With hospital and nursing home care, Medicare pays for room and board, as well as for extensive custodial services. At home, these services are provided by family members or paid out-of-pocket by individuals without family support. Family members are frequently trained to render semi-skilled support services for home health care patients. Family caregivers already have enormous physical, mental and financial burdens, providing an estimated \$450 billion a year in unpaid care to their loved ones,^{xiii} and too frequently having to cut their work hours or quit their jobs.
- **Copayments as a means of reducing utilization would be particularly inappropriate for home health care.** Beneficiaries do not “order” home health care for themselves. Services are ordered by a physician who must certify that services are medically necessary, that beneficiaries are homebound and meet other stringent standards. There is no evidence of systemic overutilization. Adjusted for inflation, home health spending on a per patient basis and overall Medicare spending on home health is less today than in 1997. The Medicare home health benefit has dropped from 9.5 percent of Medicare spending in 1997 to 5.9 percent and serves a smaller proportion of Medicare beneficiaries today than in 1997.^{xiv}
- **Home health copayments would shift costs to the states.** About 15 percent of Medicare beneficiaries receive Medicaid. Studies have shown that an even larger proportion (estimated to be about 25 percent by the Medicare Payment Advisory Commission (MedPAC)) of Medicare home health beneficiaries are eligible for Medicaid. A home health copayment would shift significant costs to states that are struggling to pay for their existing Medicaid programs. In addition, states would have to pick up their Medicaid share of new QMB assistance obligations.
- **Medicare supplemental insurance cannot be relied upon to cover home health copays.** There is no requirement that all Medigap policies cover a home health copay and only 17 percent of Medicare beneficiaries have Medigap coverage. For the 34 percent of Medicare beneficiaries who have supplemental coverage from an employer sponsored plan, there is no assurance that these plans will be expanded to cover a home health copay or remain a viable option for beneficiaries, given the current trend of employers dropping or reducing retiree

coverage.^{xv} Likewise, the 25 percent of beneficiaries enrolled in Medicare Advantage (MA) plans would not be protected from a home health copay, as many MA plans have imposed home health copays even in the absence of a copay requirement under traditional Medicare.

- **Copayments would impose costly administrative burdens and increase Medicare costs.** Home health agencies would need to develop new accounting and billing procedures, create new software packages, and hire staff to send bills, post accounts receivable, and re-bill. Also, unlike hospitals, there is no provision for bad debt from uncollected copays currently built into the base payment for home health care. Home health agencies cannot absorb these costs as nearly 50 percent of home health agencies are projected to be paid less than their costs by Medicare. Overall home health agency margins from a combination of Medicare, Medicaid, Medicare Advantage and other payment sources average less than zero.^{xvi}

HOSPICE

The Medicare hospice benefit was created under the Tax Equity and Fiscal Responsibility Act of 1982 to expand the availability of compassionate and supportive care to Medicare's many beneficiaries suffering from terminal illness at the end of life. Eligibility for hospice is based upon a physician's certification that the patient has a terminal illness with a life expectancy of six months or less if the illness runs its normal course. When a patient elects hospice under Medicare, he or she agrees to forgo other "curative" treatment for the terminal illness. While the cost of most hospice care is covered by Medicare, the patient may be responsible for copayments related to drugs for symptom control or management and facility-based respite care. The patient is also responsible for copayments related to any regular Medicare services unrelated to the terminal diagnosis.

Congress should reject imposition of additional copayments on beneficiaries for Medicare hospice services and other changes that would discourage use of the hospice benefit. The average Medicare hospice beneficiary receives care at a cost of approximately \$11,500. With the cost sharing changes that have been proposed, a 20 percent copay would impose a charge of approximately \$2,300 on terminally ill individuals in the last days of their lives. Given the requirement that a patient be determined to be terminally ill with a plan of care developed by an interdisciplinary team, there is no need for an additional check on utilization of care. Implementing a Medicare copayment for these services would cause many terminally ill patients to second guess their physician and care team in the last days of their life.

Historically, copayments have been imposed on health care services to reduce overutilization of services. While use of hospice services has grown significantly through the years, many Medicare beneficiaries are referred to hospice too late to reap its full benefit, and many more lack sufficient knowledge or understanding of hospice to consider it a viable option at the end of their lives. This is particularly the case for minority and low-income Medicare populations — who are the least likely to be able to afford additional cost-sharing burdens.

Beneficiaries who elect Medicare hospice services must agree to forego curative care for their terminal illness. Given that many "curative" interventions for terminal illnesses can involve administration of costly new medications and treatments, it is not surprising that numerous

studies have documented that appropriate use of hospice services can actually reduce overall Medicare outlays while at the same time extending length and quality of life for enrolled beneficiaries.^{xvii}

While valid concerns have been raised about the length of time some Medicare beneficiaries are on hospice service, the median length of stay under the hospice benefit is about 17 days, and 95 percent of hospice care is provided in the home. Congress has already addressed concerns relative to extended length of stays in hospice care by requiring a face-to-face encounter prior to the start of the third and later benefit periods. Through that change, ineligible individuals are screened out and improper Medicare payments are avoided. In lieu of imposing additional beneficiary cost-sharing that could discourage appropriate and desirable use of the hospice benefit, Congress and other policymakers should explore additional ways to ensure that hospice services are being ordered for patients that are truly eligible, such as through physician education.

PROPOSALS TO ADDRESS CONCERNS ABOUT PROGRAM INTEGRITY

Rather than applying a copay to address concerns that have been raised about possible overutilization and wasteful spending on home health services in certain parts of the country, NAHC suggests targeted approaches that do not restrict access to care and penalize Medicare beneficiaries and ethical home health providers. It is essential that Medicare operate with integrity and compliance as millions of Americans depend on this program every day to meet their health care needs. Eliminating wasteful spending should be the highest priority in that regard. For too long, honest and compliant providers and beneficiaries have had to pay through increased costs, reduced benefits, and payment rate reductions for the misdeeds and criminal conduct of bad actors that seek to take advantage of systemic weaknesses in Medicare. NAHC fully supports efforts to address these weaknesses with constructive and well-focused action. The home care and hospice community recognizes that they must be responsible stewards of the limited resources available to Medicare. We also recognize that it is a privilege to be a participating provider in these programs and that we can be effective partners with government in combatting fraud, waste, and abuse.

In recent years, new policies and administrative practices have been instituted to address care overutilization concerns. For example, Medicare has added oversight and "real-time" predictive modeling to target aberrant providers, using its contractors such as the Zone Program Integrity Contractors (ZPICs) and Recovery Audit Contractors (RACs) in addition to its longtime claims reviews by the everyday Medicare Administrative Contractors (MACs). Also, an industry-developed restriction on home health outlier episodes in home health services eliminated abusive claims, reducing unnecessary Medicare spending by \$1 billion in its first year, 2010.

Other measures have been instituted by Medicare, including more stringent provider participation standards, a periodic professional therapist assessment requirement prior to continued care, and a physician face-to-face encounter requirement to initiate covered home health services. These and other changes have led to an actual reduction in Medicare home health spending, a phenomenon unique in the Medicare program in recent years. In fact, home health

spending and utilization is less today than in 1997. In today's dollars, Medicare home health spending is about 40 percent lower than in 1997 while all other sectors have significantly increased. Still, home care and hospice wish to lead rather than follow in program integrity innovations.

In that spirit, we offer ten recommendations that we believe can further reduce wasteful spending and prevent fraudulent conduct. These recommendations include a combination of steps that are directed to the primary reason that concerns about fraud and abuse exist – the system permits bad actors and parties without adequate competencies to enter Medicare program. In addition, these recommendations also offer a series of improvements focused on existing providers of care designed to ensure ongoing and continuous compliance. These recommendations are designed to address both deliberate fraud and abuse and harm caused by ignorance or lack of competence.

- 1) **Implement a targeted, temporary moratorium on new home health agencies.** CMS has expressed growing concerns about the entry of fraudulent providers into the Medicare program. With respect to Medicare home health services, there is strong evidence that much of the fraud, waste, and abuse stems from the entry of new providers in areas of the country already saturated with existing home health agencies. CMS has not exercised its authority to impose targeted moratoria on new home health agencies in spite of the evidence that certain areas of the country already have too many providers. Congress should mandate the implementation of a temporary, targeted moratorium on new home health agencies in geographic areas where there is a highly disproportionate number of providers relative to the number of beneficiaries in an area. It should apply certain standard exceptions to a moratorium such as where the state has a Certificate of Need program and the state determines that there is a need for additional providers; the provider is establishing a branch office or multiple locations within its geographic service area; or the provider has submitted the appropriate CMS Form 855A prior to the public notice of any moratorium.
- 2) **Require credentialing of home health agency executives.** Strengthen Medicare program participation standards to include experience, credentialing and competency testing of home health agency owners, managers, and personnel responsible for maintaining compliance with Medicare standards. Competency credentialing should be made part of the Medicare provider screening model and applied to both new and existing providers of home health services. The credentialing should include minimum training and competency testing of owners and managers in all areas of Medicare/Medicaid operations including coverage standards, claim submission, cost reporting, and compliance requirements under the anti-kickback laws and the Stark law provisions.
- 3) **Expedite refinements to the Medicare home health payment system to eliminate incentives to over-utilize care.** The current home health prospective payment system (HHPPS) includes higher reimbursement for episodes with more therapy visits. Reimbursement for episodes increases incrementally as the number of therapy visits increase. Any episodic prospective payment system that relies on the volume of services to determine payment amounts raises the risk of service overutilization. The current case mix adjustment model for home health services payment should be modified to eliminate

the use of a payment modifier based on the volume of therapy visits. Sufficient Medicare resources should be invested to expedite refinements to the Medicare home health payment system so that the provision of services is better aligned with patient characteristics and costs of providing care, rather than the number of visits provided per episode for any service.

- 4) **Require all Medicare participating home health agencies to implement a comprehensive corporate compliance plan.** Congress should require expedited implementation of corporate compliance plans by home health agencies to ensure adherence to all federal and state laws with proper funding support. Compliance program implementation, development and maintenance should include the following: corporate compliance plan frameworks based on the elements put forth in the Sentencing Guidelines; tailored to address specific risk areas; periodically re-evaluated; taken into consideration by CMS when making payment rate changes; outreach and education activities by CMS for providers to implement a compliance plan; and 12 months to fully implement a compliance plan following the publication of any rule.
- 5) **Strengthen admission standards for new Medicare home health agencies through probationary initial enrollment, prepayment claims review, increased initial capitalization requirements, and early-intervention oversight by Medicare surveyors.** CMS has implemented provider screening, including fingerprinting. However, participation standards should be established to further reduce the risk that unscrupulous, as well as inexperienced providers continue to manage to obtain Medicare participation agreements on the front-end. Congress should increase the initial capitalization requirements to the equivalent of one year operation; establish a “probationary enrollment” for new providers during which all new home health agencies are subject to 100 percent medical review for at least 30 days, followed by a minimum of 10 percent medical review for the first year in the program; establish a mandatory in-service training requirement during the probationary period on regulations and policies including coverage standards, claim submission, cost reporting, and compliance requirements under the anti-kickback laws and the Stark law provisions; conduct State Agency full resurveys of all new home health agencies at 6 months of operation; and require training for all State surveyors in coverage standards, with reporting of questionable billing practices to the MACs.
- 6) **Create a joint Home Health Benefit Program Integrity Council to provide a forum for partnering in program integrity improvements with Medicare, Medicaid, providers of services, and beneficiaries.** Congress should establish a Medicare Home Health Benefit Program Integrity Advisory Council appointed by the Secretary of HHS with representation from Medicare beneficiaries, home health agencies, organizations representing beneficiaries and home health agencies, the Centers for Medicare and Medicaid Services, the Office of Inspector General of the US Department of Health and Human Services, and the US Department of Justice. Its purpose is to: evaluate and assess existing compliance oversight systems and system performance within the Department of Health and Human Services and its contractors regarding quality of care, coverage of services, and compliance with program integrity laws and regulations; recommend

compliance oversight system improvements that should be developed and implemented by the Secretary; evaluate and assess existing compliance oversight systems within home health agencies and system performance regarding quality of care, coverage of services, and compliance with program integrity laws and regulations; and recommend compliance oversight system improvements that should be developed and implemented by home health agencies.

- 7) **Require criminal background checks on home health agency owners, significant financial investors, and management.** A key to program integrity in Medicare and Medicaid home care starts at the top. Congress should require criminal background check requirements on all individuals seeking to open and operate an agency and those who finance the creation of the agency. Medicare participation should be denied to any prospective owner where that owner or party providing the financial capital to open the home health agency has a criminal background that involves patient abuse, neglect, or misappropriation of patient property or involves a financial related crime that indicates a risk to the integrity of Medicare.
- 8) **Establish authority for a self-policing compliance entity to supplement and complement federal and state oversight.** Government enforcement entities do not have sufficient resources to address all concerns regarding fraud, waste and abuse in federal health care programs. Congress should authorize the establishment of private enforcement and sanction power by an industry-sponsored entity as an adjunct and complement to existing federal enforcement powers. The entity would be industry-financed, subject to operational standards developed by HHS, and open and transparent in a manner equivalent to a federal agency. The private enforcement entities would be authorized to impose monetary and operational sanctions on Medicare/Medicaid participating providers of care, including suspension of the provider participation agreement, institution of corporate integrity agreements, and fines for noncompliance. The entities would have audit authority in order to engage in an investigation of alleged noncompliance.
- 9) **Enhance education and training of health care provider staff, regulators and their contractors to achieve uniform and consistent understanding and application of program standards.** The Medicare home health benefit is governed by complex laws and regulations that lead to misinterpretation of coverage, payment, and program integrity rules. In addition, providers frequently receive conflicting information from various sources involved in enforcing program integrity. Congress should ensure that education and training of the Medicare program is a joint effort among home health providers, regulators, state surveyors, and Medicare contractors by taking the following steps: develop education sessions to be conducted nationally and open to all stakeholders; provide educational resources that are accessible and that provide clear interpretations to CMS regulations and policies; require greater transparency on instructions provided to the Medicare contractors on payment, coverage, and program integrity policies; and abandon use of local coverage decisions (LCD) and require that only national coverage decisions be used for coverage and payment guidelines.

- 10) **Utilize targeted provider edits for application of claims reviews and oversight activities. In Medicare home health services, the variation in utilization warrants careful attention.** While the benefit may offer a wide range of services to be covered and permit coverage of extended periods of care, extreme instances of high levels of utilization should be subject to increased scrutiny. For example, MedPAC has highlighted the 25 counties with the highest level of utilization. In some instances, providers have twice the national average in the number of episodes per beneficiary per year. Although beneficiaries can qualify for an unlimited number of 60 day episodes in a calendar year, the extraordinary difference between national average utilization and these providers should trigger claims reviews, including a prepayment authorization process. Such an episode volume process edit will require providers to prove that their claims meet coverage standards.

In relationship to hospice care, NAHC's affiliated Hospice Association of America (HAA) has developed a similar list of program integrity recommendations that we would be happy to supply to the Committee.

MEDICARE INNOVATIONS TO PROMOTE HIGH QUALITY CARE AT LOWER COST

NAHC suggests the following reforms in the Medicare benefit structure that would incentivize high quality care while saving Medicare dollars:

- 1) **Ensure home care and hospice participation in transitions in care, accountable care organizations, chronic care management, health information exchanges, and other health care delivery reforms.** Congressional reforms of the health care delivery system recognize home care and hospice as key partners in securing high quality care in an efficient and efficacious manner. Congress should monitor closely CMS's implementation of the health care delivery reform provisions in the Patient Protection and Affordable Care Act (PPACA) to ensure that the intended goals are fully met. Congress should encourage CMS to look to home care and hospice as part of the solution to rising health care spending in Medicare and Medicaid, including through community based chronic care management. Congress should investigate and remove any existing laws and regulations that create barriers to the inclusion of home care and hospice entities as integrated partners or participants with other health care organizations in transitions in care actions, bundling of payments, or other delivery of care innovations.
- 2) **Allow nurse practitioners and physician assistants to sign home health plans of care.** Congress should enact the bipartisan Home Health Care Planning Improvement Act that would allow Nurse Practitioners (NP) and Physician Assistants (PA) to certify and make changes to home health plans of treatment. NPs and PAs are playing an increasing role in the delivery of our nation's health care, especially in rural and other underserved areas. Medicare reimburses NPs and PAs for providing physician services to Medicare patients. NPs and PAs can certify Medicare eligibility for skilled nursing facility services, but not more cost effective care in the home.

- 3) **Recognize telehomecare interactions as bona fide Medicare services.** Congress should: 1) establish telehomecare services as distinct benefits within the scope of Medicare coverage guided by the concepts embodied in the Fostering Independence Through Technology (FITT) Act, which should include all present forms of telehealth services and allow for sufficient flexibility to include emerging technologies; 2) clarify that telehomecare qualifies as a covered service under the Medicare home health services and hospice benefits and provide appropriate reimbursement for technology costs; 3) expand the list of authorized originating sites for telehealth services by physicians under section §1834(m)(3)(C) to include an individual's home; and 4) ensure that all health care providers, including HHAs and hospices, have access to appropriate bandwidth so that they can take full advantage of advances in technology appropriate for care of homebound patients.
- 4) **Ensure appropriate development of performance-based payment for Medicare home health services.** MedPAC has recommended application of a "pay for performance" (P4P) system for home health and other Medicare provider payments. Starting in 2008, Medicare began a P4P demonstration project operating in seven states. Under that demo, home health agencies qualify for incentive payments based on high quality of care performance or improvement in performance from the previous year. The incentive payments are based upon the impact that the performance has had on reducing Medicare costs in other health care sectors, including hospital care. This approach recognizes the dynamic value that high quality home health services can have in reducing overall health care spending. Congress should monitor the progress of the ongoing P4P demonstration and use the findings to guide its consideration of a full-fledged value-based payment system for Medicare home health services.

ⁱ Urban Institute Health Policy Center, "A Preliminary Examination of Key Differences in Medicare Savings Bills," July 13, 1997.

ⁱⁱ Trivedi, Amal N., Husein Moloo and Vincent Mor, "Increased Ambulatory Copayments and Hospitalizations among the Elderly," *New England Journal of Medicine*, January 2010.

ⁱⁱⁱ National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplemental Insurance First Dollar Coverage and Cost Shares Discussion Paper" (October 2011).

^{iv} Leighton Ku and Victoria Wachino, "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Findings," Center on Budget Priorities (July 7, 2005).

^v U.S. Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, "VA Eliminates Copayment for In-Home Video Telehealth Care," May 8, 2012.

^{vi} Avalere Health LLC, "Potential Impact of a Home Health Co-Payment on Other Medicare Spending," July 12, 2011.

^{vii} CMS Office of Information Services, Medicare & Medicaid Research Review/2011 Supplement, Table 7.2.

^{viii} Avalere Health LLC, "A Home Health Copayment: Affected Beneficiaries and Potential Impacts," July 13, 2011.

^{ix} The Commonwealth fund, "One-Third At Risk: The Special Circumstances of Medicare Beneficiaries with Health Problems," September 2001.

^x "Medicare at a Glance," Kaiser Family Foundation, November 2011.

^{xi} "Health Care on a Budget: The Financial Burden of Health Care Spending by Medicare households"—Kaiser Family Foundation.

^{xii} "Government Accountability Office, "Medicare Savings Programs: Implementation of Requirements Aimed at Increasing Enrollment," GAO-12-871 (September 2012).

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- ^{xiii} L. Feinberg, S.C. Reinhard, A. Houser, and R. Choula, "Valuing the Invaluable: 2011 Update, the Growing Contributions and Costs of Family Caregiving," AARP Public Policy Institute Insight on the Issues 51 (Washington, DC: AARP, June 2011).
- ^{xiv} CMS Research, Statistics, Data, and Systems/Statistics, Trends and Reports, Medicare Medicaid Stat Supp/2011 (Tables 3.1 and 7.1).
- ^{xv} Kaiser Family Foundation, "Examining Sources of Supplemental Insurance and Prescription Drug Coverage Among Medicare Beneficiaries: Findings from the Medicare Current Beneficiary Survey, 2007," August 2009.
- ^{xvi} National Association for Home Care & Hospice (NAHC) Cost Report Data Compendium, Updated 2012.
- ^{xvii} Duke University, "What Length of Hospice use Maximizes Reduction in Medicare Expenditures Near Death in the U.S. Medicare Program," Social Science and Medicine 65 (2007).



February 26, 2013

The Honorable Kevin Brady
Chairman
Ways & Means Subcommittee on Health
Washington, D.C. 20515

The Honorable Jim McDermott
Ranking Member
Ways & Means Subcommittee on Health
Washington, D.C. 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of AARP's 37 million members and the millions of Americans with Medicare, thank you for holding a hearing to examine traditional Medicare's benefit design. Medicare continues to play a vital role in the health and financial security of older Americans. We have long recognized the need to strengthen and improve the program and appreciate that the committee is considering ways to do so. As Congress considers various proposals, we urge you to examine all the potential ramifications on beneficiary out-of-pocket spending, access to needed care, and total costs to the health care system.

As you know, the current Medicare fee-for-service (FFS) benefit structure requires beneficiaries to meet separate annual deductibles for Part A (hospital insurance) and Part B (medical insurance, including physician visits) services. For 2013, the Part A deductible is \$1,184 and the Part B deductible is \$147 respectively. After meeting the deductibles, a beneficiary faces wide variation in coinsurance, depending on the type of service he or she receives. For example, in Part A, a beneficiary pays for a daily rate if she requires more than 60 days in an inpatient hospital, and she pays a daily coinsurance starting on the 21st day in a skilled nursing facility (SNF). In Part B, a beneficiary pays for 20 percent of the cost of care except for home health services and some preventative care services, which are fully paid by Medicare.

There are notable gaps in current Medicare benefits, including the lack of a catastrophic cap and coverage for certain essential health benefits. In recent years, the creation of the Medicare Part D drug benefit in 2006 and the phasing out of the coverage gap, or "doughnut hole", in Part D – as required by the Affordable Care Act – have been major improvements. Yet, even with these improvements, out-of-pocket costs still remain a great burden for many Medicare beneficiaries. Analysis by AARP's Public Policy Institute finds that at least 50 percent of Medicare beneficiaries – who have incomes of roughly \$20,000 – spent \$3,100 on health care expenses, or nearly 17 percent of income, in 2007 (the most recent year for which Medicare Current Beneficiary Survey data were available). Ten percent of beneficiaries spend over \$7,800 on health care costs.¹ The report also finds that out-of-pocket spending is higher for older and poorer beneficiaries: spending increases to over 20 percent of their income on health care.

¹ C Noel-Miller, "Medicare Beneficiaries' Out-of-Pocket Spending for Health Care", AARP Public Policy Institute, Washington, DC, May 2012. Includes spending for Medicare and supplemental premiums, and for medical services and some long-term services and supports.
http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-beneficiaries-out-of-pocket-spending-AARP-ppi-health.pdf

Without an out-of-pocket cap, the traditional Medicare program currently leaves beneficiaries at risk for significant cost-sharing if they become seriously ill or need to manage chronic health conditions. No other public or private health insurance plan imposes the same level of risk on their participants: these plans generally limit the amount of cost-sharing that participants have to pay in a year or a lifetime. As a consequence, most Medicare beneficiaries rely upon other supplemental insurance to avoid the potential risk of significant out-of-pocket costs (e.g. employer-provided retiree health and Medigap) or rely on Medicaid. Not all beneficiaries have supplemental insurance coverage, however. About 4 million beneficiaries (8%) have no additional coverage, and potentially face significant health care expenses should they become seriously ill.

Since the enactment of the Medicare program, health care has changed significantly. Prescription drug treatments have grown substantially in importance, and technology has provided a range of new treatment interventions. Further, more treatments are provided on an outpatient basis and the cost of health care has grown dramatically. Reexamining the Medicare benefit package to evaluate options to better serve the health care needs of beneficiaries, maintain the affordability of the program, and improve program efficiency is an important goal.

In exploring any Medicare redesign, AARP believes that it is essential to look at any proposed changes from the perspective of beneficiaries, not just from the perspective of a budget score. In fact, they are not and they will be affected differentially. The impact will depend on the types of services they use, the intensity of their use, whether and what type of supplemental coverage they have, and their income. Those without supplemental coverage will be most directly impacted by increases in cost sharing. Research shows that individuals, particularly those who are sicker and poorer, react to higher cost sharing by avoiding or delaying use of health care services, including necessary care. In particular, this would apply to services that currently require no coinsurance or limited coinsurance, such as inpatient hospital services or hospice. The avoidance of needed care could lead to a faster or more serious decline in health, which not only has adverse consequences for the beneficiary, but potentially could end up costing the health care system more.

In addition, any redesign of Medicare cost-sharing will potentially affect various groups of Medicare beneficiaries differently. All too often, proposals are evaluated as if all beneficiaries are identical. In fact, they are not and they will be affected differentially. The impact will depend on the types of services they use, the intensity of their use, whether and what type of supplemental coverage they have, and their income. Those without supplemental coverage will be most directly impacted by increases in cost sharing. Research shows that individuals, particularly those who are sicker and poorer, react to higher cost sharing by avoiding or delaying use of health care services, including necessary care. In particular, this would apply to services that currently require no coinsurance or limited coinsurance, such as inpatient hospital services or hospice. The avoidance of needed care could lead to a faster or more serious decline in health, which not only has adverse consequences for the beneficiary, but potentially could end up costing the health care system more.

Beyond the immediate impact on beneficiary out-of-pocket costs, redesigning the Medicare benefit will have several other implications:

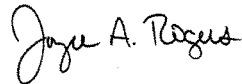
- Depending upon the new cost sharing design, other types of supplemental coverage (e.g., Medigap, TRICARE, VA) will also be affected. It will be important to analyze the interaction of multiple policy changes.
- State Medicaid programs could incur added liability for cost sharing of dually eligible beneficiaries.
- Employer plans that contribute towards the cost of retiree health insurance, which is the most prevalent form of supplemental coverage, could also see added liability.
- A catastrophic cap would put an annual limit on Parts A and B, but would likely be separate from the catastrophic coverage in Part D, and may not apply at all to non-Medicare costs, such as dental, hearing, vision and long term care.

Finally, Congress must consider Medicare benefit redesign in the context of broader reforms to the health care system. Even though redesigning the Medicare benefit package may reduce federal Medicare expenditures, it is likely to result in merely cost-shifting to beneficiaries and other payers,

and do little or nothing to reduce overall health care spending. In fact, Medicare spending growth is already moderating. According to the Congressional Budget Office, from 2007 to 2012, Medicare spending growth has averaged only 1.9 percent per year. In February 2013, the CBO reduced its estimate of projected 2013-2022 spending for the Medicare programs by about \$143 billion. Moreover, Medicare spending increased only 0.4 percent per beneficiary in 2012; substantially below the growth in GDP of 3.4 percent per capita. With the rate of Medicare growth stabilizing, to focus solely on Medicare benefits to achieve health care savings misses the larger drivers of health care costs throughout the health care system.

Again, we thank you for holding a hearing to explore Medicare benefit redesign. Medicare reform should be done cautiously and deliberatively, in an effort to minimize impacting the beneficiaries who rely on the program for their health and financial security. If you have any questions, please feel free to call me, or have your staff contact Ariel Gonzalez of our Government Affairs staff at agonzalez@aarp.org or 202-434-3770.

Sincerely,

A handwritten signature in cursive script that reads "Joyce A. Rogers".

Joyce A. Rogers
Senior Vice President
Government Affairs

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS
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July 24, 2013

Dr. Katherine Baicker
Professor of Health Economics
Department of Health Policy and Management
Harvard School of Public Health
677 Huntington Avenue
Boston, MA 02115

Dear Dr. Baicker:

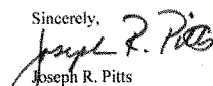
Thank you for appearing before the Subcommittee on Health on Wednesday, June 26, 2013, to testify at the hearing entitled "A 21st Century Medicare: Bipartisan Proposals to Redesign the Program's Outdated Benefit Structure."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Wednesday, August 7, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Sydne.Harwick@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment



HARVARD SCHOOL OF PUBLIC HEALTH
DEPARTMENT OF HEALTH POLICY AND MANAGEMENT

KATHERINE BAICKER
PROFESSOR OF HEALTH ECONOMICS

August 6, 2013

**RESPONSES TO QUESTIONS FOR THE RECORD
June 26 Hearing, "A 21st Century Medicare"
House Committee on Energy and Commerce**

Thank you for the opportunity to respond to these additional questions from the **Honorable Gus Bilirakis**:

1. **One of the greatest challenges of health care is the issue of price transparency. Health care is one of the biggest sectors of our economy where no one knows the cost of a service. Under a co-pay system, a patient could know the cost of a medical service in advance, but that cost does not necessarily represent the total actual cost of the service. Under a co-insurance system, a patient might not know the cost of a service until after the service is performed. When designing a new benefit structure, how can we increase the level of transparency in the system so beneficiaries can know what their costs will be before they even visit the doctor?**

I believe that price and quality transparency are crucial to enabling competitive forces to drive lower cost and higher value. Patients need information about quality and price to choose insurance plans and health care providers that give them the care that is right for them. Furthermore, the uncertainty generated by ill-defined coinsurance creates anxiety for patients as well as barriers to informed decision-making. Beneficiaries need clear advance information not only about prices of individual services and the quality and value offered by different providers, but also about how different benefit structures affect the premiums they face so that they can choose not just the best providers but also the ideal insurance plan based on cost-sharing, networks, and other features designed to enhance value.

2. **Traditional Medicare Fee for Service operates in two different silos, Part A & B, without either part talking to each other. Medicare Advantage provides a comprehensive benefit with coordination between hospital and outpatient settings. Do we have data evaluating Medicare Advantage against traditional fee-for service? From your perspective, what lessons from Medicare Advantage can we apply to redesigning traditional Medicare?**

There are several studies suggesting that Medicare Advantage (MA) does indeed provide beneficiaries with higher quality and value coordinated care (see, for example, Landon et al., "Analysis of Medicare Advantage HMOs Compared with Traditional Medicare Shows Lower Use of Many Services During 2003-9," *Health Affairs*, 31(12), 2012; Ayanian et al., "Medicare

Beneficiaries More Likely to Receive Appropriate Ambulatory Services in HMOs than in Traditional Medicare," *Health Affairs*, 32(7), 2013), suggesting that there could be substantial gains to better coordination of care for fee-for-service enrollees. This line of research is hampered, however, by the limited data available on the care consumed by MA enrollees. Encounter data for MA enrollees parallel to the claims data available for fee-for-service enrollees would greatly facilitate these important comparisons and should be made available to researchers.

I hope that this information is helpful. Please do not hesitate to contact me if I can be of further service.

Sincerely,



Katherine Baicker

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (203) 226-2927
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July 24, 2013

Dr. Patricia Neuman
Senior Vice President
The Henry J. Kaiser Family Foundation
1330 G Street, N.W.
Washington, D.C. 20005

Dear Dr. Neuman:

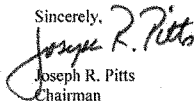
Thank you for appearing before the Subcommittee on Health on Wednesday, June 26, 2013, to testify at the hearing entitled "A 21st Century Medicare: Bipartisan Proposals to Redesign the Program's Outdated Benefit Structure."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Wednesday, August 7, 2013. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Sydne.Harwick@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Response to the Honorable Gus Bilirakis from the June 26, 2013, hearing entitled “A 21st Century Medicare: Bipartisan Proposals to Redesign the Program’s Outdated Benefit Structure.”
Dr. Tricia Neuman

Congressman Bilirakis, you raise an important point about price transparency. In general, it is not easy for patients to anticipate the cost of a given medical service before they receive it – either the cost they are likely to incur out-of-pocket or the cost that will be paid by insurers, such as Medicare. Under traditional Medicare, the use of coinsurance rates, rather than copayments, makes it especially challenging for beneficiaries to calculate their own liability, primarily because they would first need to know the underlying cost of a given service allowable under Medicare, before calculating their share of that total fee.

Introducing copayments for services covered under Medicare Parts A and B, rather than coinsurance rates, would make it easier for beneficiaries to anticipate the costs they are likely to incur for a given service, such as a physician visit or diagnostic test. Several recent proposals would restructure the Medicare benefit design in a manner that would replace current law coinsurance rates with copayments for various services. MedPAC, for example, suggested a benefit design that included fixed copayments for inpatient stays, physician visits (with higher copayments for specialty than primary care), post-acute care and other services. The Bipartisan Policy Center recommended a similar benefit design that relied more heavily on copayments than coinsurance. Such copayments would make it substantially easier for people on Medicare to anticipate their costs before they receive medical attention.

Additional steps would be needed to provide people on Medicare with information about the *total* cost of their care -- before they receive various services and treatments. Today, it is very difficult for beneficiaries to obtain this information. The shift from coinsurance to copayments would do little to achieve this objective.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
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July 24, 2013

Mr. Thomas P. Miller
Resident Fellow
American Enterprise Institute
1150 17th Street, N.W.
Washington, D.C. 20036

Dear Mr. Miller:

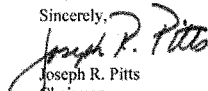
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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachment

Additional Questions for the Record for Mr. Thomas Miller

“A 21st Century Medicare: Bipartisan Proposals to Redesign the Program’s Outdated Benefit Structure”

June 26, 2013

The Honorable Gus Bilirakis

1. **One of the great challenges of health care is the issue of price transparency. Health care is one of the biggest sectors of our economy where no one knows the cost of a service. Under a co-pay system, a patient could know the cost of a medical service in advance, but that cost does not necessarily represent the total actual cost of the service. Under a co-insurance system, a patient might not know the cost of a service until after the service is performed. When designing a new benefit structure, how can we increase the level of transparency in the system so beneficiaries can know what their costs will be before they even visit the doctor?**

Increased transparency requires both stronger demand and expanded supply. The interaction between them can propel each one forward. The role of a new benefit structure is to incentivize beneficiaries to have a greater stake in knowing the costs of the health care choices they make. Increased cost sharing that focuses on the more discretionary decisions faced by beneficiaries, but caps their maximum out-of-pocket exposure to levels that they can manage, provides the best tool to increase cost consciousness. The traditional Medicare fee-for-service program performs poorly on this front. Its initial-dollar deductibles are either too small (Part B), too irrelevant to most health care decisions (Part A) that are influenced by other factors, or too hard to adjust over time. Its coinsurance under Part B is uncapped and potentially exposes beneficiaries without supplemental insurance coverage to catastrophic financial risks.

A new benefit structure should send clearer signals to which beneficiaries can respond more effectively. This hearing and my testimony has focused on reform of the traditional Medicare program, because the private plans under Medicare Advantage already have greater freedom to adopt a wider variety of benefits and cost sharing practices. They also are not as rigidly bound to the artificial distinctions between the categories of care financed under Part A (mostly inpatient hospital care) and under Part B (mostly outpatient care).

Hence, one leading option is to change traditional Medicare's cost sharing to feature a unified deductible for spending under both Part A and Part B; most likely at a level between the current ones for each respective program. A higher level of cost sharing at the front end of health spending decisions also can help finance the establishment of a maximum out-of-pocket "stop loss" limit for combined expenses under the inpatient and outpatient parts of the traditional Medicare program. If designed in a balanced manner, such cost sharing reform also can diminish the demand for supplemental Medigap insurance coverage that largely suppresses incentives for most beneficiaries to be cost-conscious and economize at point-of-service decision-making moments.

A different approach highlighted in my written testimony could involve a "major risk" type of cost sharing, which relies on an income-related stop-loss cap on all out-of-pocket expenses and a switch from front-end deductibles to a longer corridor of coinsurance at a higher rate than the current 20-percent rate for Part B.

Each type of cost sharing – deductibles, copayments, and coinsurance – has its own set of advantages and limitations regarding price transparency incentives. Deductibles send a full-strength signal regarding the complete cost of a service or procedure. But they tend to produce binary choices to either seek out and receive a particular treatment or pass it up completely. They are not as effective in encouraging beneficiaries to weigh the marginal benefits and costs of close substitutes or additional increments of care. Copayments tend to be denominated in relatively modest amounts, which provide little information about the full marginal costs of more discretionary health care decisions. Recent proposals to develop a wider variety of copayments for services, procedures, and other medical treatments tied to their relative "value" lack a sufficiently deep and robust evidence base to merit widespread application. Coinsurance provides a partial insurance cushion against the full cost of the services to which it applies, while maintaining incentives to consider their marginal out-of-pocket costs and overall value at the same time.

Even if we improve the incentives for traditional Medicare beneficiaries to want to know more about the cost of their care and then act upon it when they make health spending decisions, that alone will not fully solve the "supply" problem regarding accessible and actionable information. We need to build on recent progress in enhancing the availability of Medicare data about the relative costs of different services and patterns of treatment that are delivered by different health care providers. We also need to go well beyond a listing of simplistic price tags for isolated services and procedures and provide at least a range of estimated "all-in" costs for more complex episodes of care across multiple health care providers. Rules for which entities are allowed access to such data (while ensured full privacy protection for personal health information) should be liberalized, in order to foster stronger competition in producing patient-friendly information about the

relative cost and quality (i.e., the overall “value”) of different health care providers and the services they offer. Building a more useful and accurate information infrastructure for value-based decision making (as determined by patients, providers, and payers) will require more trial and error through competitive channels that pay attention to end users, rather than the largely top-down, centralized approach that has repeatedly stalled or failed in the past.

The Honorable Gus Bilirakis

2. **Is it worthwhile to have multiple Medicare plans in the marketplace? CMS could establish an actuarial value and allow various plans of different premiums/deductibles/cost-shares. This would allow seniors to choose a plan that fits their lifestyle and health status rather than a one-size-fits-all plan.**

Medicare beneficiaries have already voted with their feet and their wallets. They very much welcome and value a wider variety of Medicare plans – both as alternatives to traditional Medicare services under Parts A & B, and as a competitive marketplace for either integrated or stand-alone prescription drug coverage under Part D. Competition and choice among Medicare plans helps match them with the diverse preferences and needs of beneficiaries. The rules for structuring this competition among private Medicare plans, as well as between them and the traditional Medicare program, have evolved and generally improved over time, after more mixed experience in earlier iterations (such as private plan options under the TEFRA rules of the 1980s and early 1990s for Medicare HMOs, the ill-fated Medicare+Choice rules under the Balanced Budget Act of 1997, and even the early, over-generous bidding benchmarks set under the Medicare Modernization Act of 2003) failed to ensure competition in cost-effectiveness. Risk adjustment has improved over the last decade, though it remains far from perfect. Finding a sustainable formula for level-playing-field competition between Medicare Advantage plans and traditional Medicare that improves the mix of cost and quality remains elusive, although better models of “premium support” could and should be considered. Establishing an actuarial value for the baseline level of taxpayer assistance under an improved system of Medicare plan competition (ideally first determined through “competitive bidding” ground rules rather than by budget-driven political calculations alone) would allow competing plans to offer different baseline-benefit mixes of comparable value. At the same time, beneficiaries should be allowed and encouraged to seek enhanced plan choices when they are willing to spend more of their own money to purchase them.

The Honorable Gus Bilirakis

- 3. Traditional Medicare Fee for Service operates in two different silos, Part A & B, without either part talking to each other. Medicare Advantage provides a comprehensive benefit with coordination between hospital and outpatient settings. Do we have data evaluating Medicare Advantage against traditional fee-for-service? Does Medicare Advantage provide lower costs and better outcomes compared to traditional fee-for-service? What lessons from Medicare Advantage can we apply to redesigning traditional Medicare?**

We have some limited data in published research that tells a mixed story. In general, Medicare Advantage (MA) plans -- particularly private HMO plans -- have demonstrated better health quality ratings and better outcomes compared to traditional Medicare (FFS) for a number of standard measures. The evidence regarding relative cost-effectiveness is clouded by changing payment methods over time, plus difficulty in accounting for all of the relative advantages and disadvantages within the different features of MA and FFS.

For example, a study in the February 2012 issue of the *American Journal of Managed Care* found that 30-day hospital readmission rates were 13 percent to 20 percent lower in MA plans than for traditional Medicare FFS. A peer-reviewed 2007 study in *Medical Care Research and Review* found that beneficiaries in Medicare HMOs have fewer avoidable hospitalizations than Medicare FFS beneficiaries. MA beneficiaries also are less likely to report trouble in receiving care, more likely to receive necessary preventive services, and more likely to have a usual source of care.

In comparing the costs of MA plans versus FFS, it depends on whether is measuring cost-effectiveness in delivering comparable basic benefits or evaluating total costs under different methods of reimbursement. In recent years, MedPAC analysis has found that MA plan benchmark bids for similar beneficiaries have been below those of Medicare FFS (96 percent in 2013, down from 98 percent in 2012). The most common type of MA plans --- Medicare HMOs -- have performed even more efficiently; bidding 92 percent of FFS spending in 2013. However, additional benchmark reimbursement formulas have raised overall taxpayer spending on MA plans above that of comparable FFS rates in many market areas. MA plans have directed these additional payments primarily toward enhanced benefits, and somewhat lower cost sharing, for beneficiaries in order to increase their market share. MA advocates also point out that the somewhat higher reimbursement rates help to compensate for the longstanding advantages of FFS as an entrenched, dominant incumbent within the Medicare program (including being the default selection for newly eligible seniors and retaining the legal authority to dictate its own administered prices to

providers). They also note that a full accounting of comparable costs should include the supplemental Medigap premiums that many FFS beneficiaries have to pay to gain access to MA-equivalent benefits.

Although some disagreement among outside analysts remains about the accuracy of risk adjustment mechanisms in ensuring apples-to-apples cost comparisons between MA and FFS, a more aggressive version of premium support financing of Medicare options on a level playing field (such as proposed by several of my AEI colleagues) would deliver larger taxpayer savings and push both MA plans and the traditional FFS program to lower their costs and improve their quality.

The most important lessons to be learned from MA are that coordinating and integrating care to treat the “whole patient” improves health outcomes and lowers costs. Having to attract and retain Medicare beneficiaries, instead of automatically enrolling them when they reach the age of eligibility, also sharpens accountability for performance in a patient-centered manner. The MA side of the Medicare program also is more open to innovation in health care treatment and health plans’ adoption of successful practices implemented by their competitors. Applying these lessons to the traditional FFS program is more difficult, but not impossible; such as in better versions of current experiments with accountable care organizations, medical homes, bundled payment, and value-based reimbursement. Breaking down the arbitrary payment silos that separate Part A and Part B of FFS, as well as integrating cost-sharing provisions across the continuum of care, would represent a good start.

The Honorable Gus Bilirakis

4. **There is concern that MediGap plans driving up cost, providing less benefit for seniors, and we should think about alternatives to those plans. What if we gave everyone an HSA? Millions of Americans have an HSA today and they will age into the Medicare population. Do we have data, on average, how much seniors would have in an HSA as they entered Medicare, or could have, if HSA's were more widespread and used over a lifetime? If seniors had HSA's with a lifetime of savings in it, there would be less need for MediGap policies, and seniors would be better equipped to cover sudden health care spending spikes.**

Wider access to HSAs, and greater use of time, can help contribute to post-retirement assets for health care needs. The size of retained balances at age 65 are sensitive to underlying assumptions about interest rates, duration of HSA-contribution eligibility, levels of contributions, and retention of HSA contributions over time as savings rather than for pre-retirement health care spending. The earliest rough model for potential net savings from tax-advantaged health accounts for active workers was provided by Eichner, McClellan, and Wise in a 1996 National Bureau of Economic Research working paper. Their study found that, within the assumed parameters of one particular individual health account model, approximately 80 percent of the employees would have retained over 50 percent of their tax-advantaged contributions by the time of retirement, and only 5 percent of the workers would have saved less than 20 percent of their contributions. The key finding was that any particular period of pre-retirement-years of high health care expenses does not persist as more and more years of health expenditures are cumulated.

A more recent analysis of likely HSA savings during pre-retirement years by the Employee Benefit Research Institute (Fronstin 2010) is more skeptical. It notes that current limits on maximum annual HSA contributions, low interest rates, and much higher post-retirement health expenses (Medicare and supplemental insurance premiums, plus other out-of-pocket expenses not covered by Medicare) indicate that retained HSA savings at the age of Medicare eligibility can make only a modest contribution (16-32 percent) to the latter. However, the EBRI study assumes only a ten-year period of HSA contributions (by a man aged 55 in 2009), primarily limits investment of contributions to low-interest savings vehicles, and predicts a substantial level of health expenses not reimbursed through Medicare (roughly half of all retiree health costs). EBRI notes that its estimates do not take into account the likely use of a share of HSA contributions for pre-retirement health care needs, plus the higher retiree health expenses faced by women (with longer average life expectancy).

The best way to view this issue is to see HSAs as a valuable contributor to increased savings for post-retiree health care needs, but not sufficient alone to fill a very large

future resource gap between expectations and personal assets. Although HSA funds cannot be used directly to pay for Medigap premiums, they can be withdrawn tax-free to pay other retiree health premiums (for Medicare Part B or Part D, for MA plans, or for employers' supplemental retiree coverage), as well as eligible out-of-pocket health expenses. Moreover, cash is fungible and assets available to handle out-of-pocket health expenses for Medicare retirees can reduce the demand, and need, for supplemental Medigap coverage.

The most recent figures for HSA balances indicate that they continue to grow (up 24 percent from 2011 to 2012, and projected to reach \$26.9 billion by 2015, according to two surveys by AHP and Devinir Research, respectively). However, more than half of current accounts have less than \$1000. The oldest accounts tabulated – those opened in 2005 – have an average balance of \$4,668. On a more promising note, the average account balance in HSAs has grown from \$1476 in December 2009 to \$2283 in December 2012. From December 2011 to December 2012, about 23 percent of total contributions made to HSAs were retained.